The **Nursing Agenda** for Michigan: 2005–2010

Actions to Avert a Crisis

COMON Coalition of **Michigan Organizations** of **Nursing**

2006

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The complete Nursing Agenda for Michigan is available online at:
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Coalition of Michigan Organizations of Nursing
COMON

January 24, 2006

The Honorable Jennifer M. Granholm
Governor of Michigan
George W. Romney Building
Lansing, Michigan 48933

Dear Governor Granholm:

The Coalition of Michigan Organizations of Nursing (COMON), representing our state's nursing community, is pleased to present to you a strategic plan for assuring a nursing workforce that is adequate in numbers and high in quality to meet the health care needs of our citizens today and into the future. **The Nursing Agenda for Michigan 2005-2010: Actions to Avert a Crisis** has been shaped by the ideas and experience of hundreds of nursing leaders and practicing nurses from a wide range of nursing specialties; it was developed in collaboration with the Office of Michigan's Chief Nurse Executive (Michigan Department of Community Health) and a broad array of other health care stakeholders.

The nursing shortage is an unprecedented one in both length and scope. It is anticipated that the shortage will be 30 years in duration. Nurses are in short supply at the state, national and global levels.

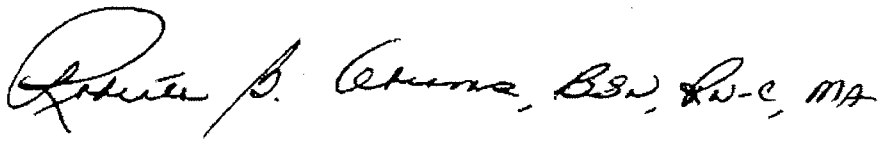
The nursing shortage is both a public health concern and an economic development issue for Michigan. The significant aging of both the nursing and the general populations, the recent catastrophic natural disasters and emerging infectious diseases intensify the need for nurses and the impact of the nursing shortage on the health and safety of Michigan citizens. From an economic perspective, Michigan's active nurses bring more than $5 billion each year to their local and state economies. The nursing shortage represents both crisis and opportunity: the strategies needed to avert the nursing shortage will also aid in addressing our state's need for more professional, stable, well-paying jobs.

Previous solutions to nursing shortages will not work in this new and complex environment of demographic extremes, public health preparedness, health systems issues, and economic issues. These times call for bold, rapid actions and responses. We believe the plan we present to you today will move Michigan in the right direction.

We call upon you, your Executive Office and related Departments, our Michigan Legislature, as well as the stakeholders in the health care, education, business and philanthropic communities to join us in this strategic venture. We greatly appreciate the support you have already provided for the new hospital, education and Regional Skills Alliances partnerships in the **Accelerated Health Care Training Initiatives.**

COMON and the Michigan nursing community, 150,000 nurses strong, pledge our support in working with you to both retain our current nursing workforce and recruit and educate the needed future nurses to secure the health and safety of Michigan citizens, as well contribute to the state's economic "health".

Sincerely,



Roberta Abrams, RN, MA, FACCE
President
Coalition of Michigan Organizations of Nursing

cc: COMON member organizations
J. Klemczak, CNE (MDCH)

The Nursing Agenda for Michigan Was Created and Endorsed by:
The Coalition of Michigan Organizations of Nursing – COMON
Member Organizations Include:

American Arab Nurses Association

American Association of Critical Care Nurses, Southeast Michigan Chapter

American Association of Occupational Health Nurses

Association of Women's Health, Obstetric, and Neonatal Nurses

Association of Rehabilitation Nurses, Michigan Chapter

Lambda Chi Chapter, Chi Eta Phi Sorority, Inc.

Detroit Black Nurses Association, Inc.

Maternal Newborn Nurse Professionals of Southeastern Michigan

Michigan Association for Local Public Health,
Health Department Nurse Administrators Forum

Michigan Association of Colleges of Nursing

Michigan Association of Nurse Anesthetists

Michigan Association of Occupational Health Nurses

Michigan Association of Occupational Health Professionals in Healthcare

Michigan Association of PeriAnesthesia Nurses

Michigan Association of School Nurses

Michigan Black Nurses Association, Inc.

Michigan Center for Nursing

Michigan Council of Nursing Education Administrators

Michigan Council of Nurse Practitioners

Michigan League for Nursing

Michigan Licensed Practical Nurses Association

COMON Member Organizations (continued)

Michigan Public Health Association, Public Health Nursing Section

Michigan Nurses Association

Michigan Organization of Nurse Executives

Michigan State Board of Nursing

National Association of Hispanic Nurses, Michigan Chapter

National Association of Pediatric Nurse Practitioners, Michigan Chapter

Philippine Nurses Association of Michigan

Other Organizations Endorsing the Nursing Agenda for Michigan

Michigan Department of Community Health
Office of the Michigan Chief Nurse Executive

Michigan Department of Labor & Economic Growth

Michigan Health Council

Michigan Home Health Association

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Preface

Why Do We Need a Nursing Agenda? Nursing care is a critical component of healthcare. Demand for healthcare – and therefore demand for nurses -- is increasing in all of the settings in which nurses practice. Michigan and the nation face a thirty-year shortage of nurses (Registered Nurses, Licensed Practical Nurses, and Advanced Practice Nurses), during which the demand for nursing services will be much higher than it is today.

We are at the beginning of a crisis. If we do nothing, our current workforce of nurses will attempt to provide preventive care and acute care for more and more people. This would be bad for the health and safety of both patients and nurses. The healthcare system as a whole would be severely impaired. Since healthcare is one of the largest segments of the Michigan economy, we all would suffer economic loss. We must act to prevent this.

How Did We Get to This Point? Our aging population increases the demand for healthcare and for nurses. The 76 million people of the Baby Boom generation now range from age 41 to 60, and already are stretching the resources of our healthcare system. Over the next thirty years, this generation will require healthcare for chronic diseases (such as diabetes), acute illness (such as heart attack and stroke), and end-of-life care. In addition, the chronic disease burden, and need for care, is increasing for people of all ages. Changes in the healthcare system have also increased the demand for nurses. Many conditions that led to hospitalization in the past now receive outpatient treatment. People admitted to hospitals today are much sicker than were people in hospitals ten years ago; their care is hi-tech, complex, and demanding. People are discharged from hospitals when they are still very sick, with recovery occurring in nursing homes or at home. In hospitals, nursing homes, home health, and other healthcare services, the majority of care is provided by professional nurses or staff supervised by professional nurses.

The supply of nurses is dependent upon the number of new nursing graduates entering the field, and the number of existing nurses remaining in the field. Over 92% of Registered Nurses are women. In the past 35 years, the range of occupations open to women has greatly expanded. Fewer young women have entered nursing than in the past, and many existing nurses have left the profession for opportunities in less physically demanding fields. The result has been a declining supply of nurses educated in the United States. Nurses from other countries have been recruited, but that is not a long-term solution. The Michigan nursing workforce is aging, with an average age of 46.1 years for Registered Nurses. The nursing faculty is older than the nursing workforce, with an average age of 51.1 years. Even if there is an increase in the number of young people seeking nursing degrees, we cannot increase nursing education's production of new nurses without additional nursing faculty.

What Do We Need To Do? The Coalition Of Michigan Organizations of Nursing (COMON) has created and endorsed the Nursing Agenda for Michigan, including the action steps we must take to ensure an adequate supply of well-prepared, high-quality professional nurses. Since the crisis has already begun, we need to take action quickly. Since the crisis will extend over the next thirty years, we need to begin actions now that will benefit all of us in the long term – so there will be nurses to care for all of us, today and in the future.

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The Nursing Agenda for Michigan: 2005 – 2010
Actions to Avert a Crisis

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Chapter 1: Why Do We Have a Nursing Workforce Crisis?

Decreasing Healthcare Resources, Increasing Healthcare Demand

The dollars available to pay for the current healthcare system in Michigan and the nation are inadequate. Public and private healthcare funding cannot keep up with increasing healthcare costs. Public health insurance, particularly Medicaid, is straining the ability of many state governments, including Michigan's, to meet the cost of healthcare for an increasing number of enrollees. Private health insurance costs are also steadily rising. Each year, additional employers find that they can no longer afford to pay for health insurance for their employees, or find that they must pass more of the premium cost to employees. Wage earners find that they cannot afford increasingly higher premiums, deductibles and co-pays.

One result of this trend is that about 15% of Americans -- more than 45 million -- are estimated to be without health insurance, a number that increases steadily. As the number of uninsured persons rises, the economic stress on the health care system increases. People with no health insurance have little access to healthcare and wait longer before seeking care. When the condition becomes acute, people with no insurance go to the emergency department of their local hospital. Emergency department treatment for acute conditions is much more expensive than primary care treatment at an earlier stage of the illness. Emergency departments are the healthcare providers of last resort.

This imbalance – expensive unpaid care for the uninsured increasing, while public and private insurance payments cover less and less of the costs – has led some healthcare systems to plan hospital closures or reductions in the ratio of staff to patients. Cost cutting efforts over the past ten years have led to increasing stress on health care providers and health care professionals. The economic buffers that used to provide a degree of protection for the American healthcare system have essentially disappeared over the past twenty years.

Adding to the seriousness of the situation are American demographics. Our population is aging, and older people need (and use) more health care. The very large Baby Boom generation (76 million born from 1945 through 1964) is now 41 to 60 years old, and already is stretching the resources of the healthcare system. Over the next thirty years, this generation will require extraordinary amounts of healthcare for chronic diseases (such as diabetes and cancer), acute illness (such as heart attack and stroke), and end-of-life care provided at home or in long-term care facilities, where LPNs are particularly important. The chronic disease burden (juvenile diabetes, for example) also is increasing for people of all ages.

An additional demand factor is the national concern about bio-terrorism, emerging infectious diseases, natural disasters, and health system preparedness (both public and private). All the strategic and operational plans for national and state responses to such threats rely on an adequate supply of healthcare services and healthcare professionals. *The nursing shortage is already at a level that has been upgraded from a health crisis to a security concern. The nation does not have adequate nurses for a situation with mass casualties or a situation threatening general public health.*[1] All of these factors – economic, demographic, emergency preparedness, and security are steadily increasing the demand for healthcare and for nurses.

One of the strategies for dealing with rising healthcare costs has been to expand the range of health conditions treated on an outpatient basis. Many conditions that previously led to hospitalization now receive outpatient treatment (ambulatory care). People admitted to hospitals today are much sicker than were the people admitted to hospitals ten years ago. The care of current hospital patients is complex and demanding, and involves increasing amounts of medical high technology. People are discharged from hospitals when they are still very sick, with recovery occurring in nursing homes or at home.

Who Provides the Majority of Healthcare?

Who provides the majority of healthcare and where is it provided? Nurses are Michigan's largest licensed healthcare professional group – 145,996 licensed in 2005 [119,152 Registered Nurses; 26,844 Licensed Practical Nurses]. In hospitals, rehabilitation centers, psychiatric mental health and substance abuse centers, public health centers, clinics, urgent care centers, physician offices, industrial health clinics, long-term care facilities, home health, prisons, State hospitals, schools, and other healthcare settings, the majority of care is provided by professional nurses, staff supervised by professional nurses, or family caregivers in the home, who are supported by nurses[2]. Without adequate numbers of professional nurses, the healthcare system cannot function. Clinics, surgical suites and maternity units close and, as happened in California, entire hospitals close due to lack of nurses.

Why Don't We Just Get More Nurses?

Healthcare providers have expended large amounts of resources trying to "just get more nurses". The nursing workforce nationally has failed to meet demand for the majority of the past 20 years, with fewer young people entering the profession, and more practicing nurses leaving the field or retiring. Healthcare providers have attempted to fill the gap by recruiting nurses from other countries, and by shifting some portion of nursing tasks to non-nursing staff. Both of these approaches are short-term solutions, with negative consequences for the long term. The Michigan Department of Labor & Economic Growth estimates that by 2010, Michigan demand will exceed supply by 7,000 nurses; by 2015, Michigan will need 18,000 more nurses than it will have[3]. We must start now if we are going to educate 7,000 new nurses in the next five years – and we must begin now to make the changes that will support education of 18.000 new nurses in the next ten years.

Preparation for nursing licensure requires from three to six years of demanding education and clinical experience. Nursing education requires that nursing faculty (both classroom and clinical) be well educated and available. Nursing faculty members are becoming scarce. The average age of nursing faculty in the United States is 51.1, and large numbers are retiring every year. In Michigan, 81% of full-time nursing faculty and 59% of adjunct nursing faculty are age 45 or older; 36% of full-time faculty and 19% of adjunct faculty are age 55 or older. A majority of Michigan nursing programs report that they have difficulty filling faculty positions[4]. The shortage of nursing faculty is much more acute than the shortage of professional nurses.

Why Hasn't Nursing Attracted More Young People?

Nursing education – and nursing as a profession – has had increasing difficulty in recruiting and retaining new members as other professional opportunities have opened up for women. From 1870 to 1970, the major professional occupations available for women were secretarial/clerical, K-12 teaching, and nursing. Women working outside the home traditionally had few respectable opportunities outside these fields. Historically, nursing and teaching have benefited from the capacities and energies of large numbers of women who could not take those capacities and energies anywhere else[5]. Historically, this narrow range of opportunities for women also has depressed salaries in nursing and teaching.

The range of career opportunities open to women has widened greatly over the past 35 years. The women of the Baby Boom generation, coming of age in the 1960s and '70s, built on the efforts of earlier advocates for women's rights and generally were successful in pursuing a wide range of educational and professional opportunities. Bright young women with good educations can now choose careers in investment banking, law, medicine, or chemical engineering (for example), or decide to start their own company in virtually any field. Nursing salaries are not competitive with those in many other fields. The women of the Baby Boom generation were the last generation to make a significant commitment to nursing; it is they who fill the ranks of nurses age 41 to 60, all of whom will be retired by 2030.

As career choices for women have widened, professional nurses already practicing have taken opportunities to move into better-paid, less physically demanding jobs in other fields. Direct-care nursing, particularly in hospitals, carries risks including: "infectious diseases ...and other dangers, such as those posed by radiation, accidental needle sticks, chemicals used to sterilize instruments and anesthetics. In addition, (nurses) are vulnerable to back injury when moving patients, shocks from electrical equipment, and hazards posed by compressed gases."[6] As direct-care clinical nurses have become scarce, nurses committed to teaching have found that clinical nursing and nursing administration jobs pay up to 20 percent more than nursing education faculty jobs[7].

Prestige does not make up for the salary deficits experienced by nurses. Physicians routinely rank number one in public ratings of prestige; nurses rank first in trust, but number 91 in terms of prestige[8]. Despite the many leadership roles for nurses, from intensive care unit administrators, to advanced practice nurses, to nurse-managed clinics, the image of nursing as manual labor primarily performed by women continues. Nursing is viewed "like motherhood – an essential but unpaid contribution to the work of society, with rewards that are largely intrinsic to the job."[9] Even within nursing there are salary and respect differentials. Public health nurses, school nurses, and other community-based nurses often receive less compensation and respect than equally credentialed hospital-based nurses[10].

National Workforce Changes: 1970-2004

The percentage of women (age 16 and over) in the national workforce has grown from 43% in 1970 to 59% in 2004 (a slight decline from the peak of 60% in 1999).[11] Over the same period, the percentage of men in the national workforce has declined from 80% to 73%. During this period, the percentage of employed women with four years or more of college increased from 11% to 33%; the comparable gain for men was from 16% to 32%. Since 1970, the growth

of the number of women in the civilian labor force has exceeded the growth of the number of men by nine million. The median salary for all employed women, as a percentage of the median for all men, rose over the past 25 years from 62% to 80%.[12] Women continue their traditional dominance in the education and healthcare professions, holding 73% of jobs in both fields. However, their jobs are not the higher paying jobs. Women are 92% of RNs and 91 % of LPNs, but only 22% of dentists and 29% of physicians[13].

Over the period from 1970 to 2004, women have increased their participation in virtually every field represented in the US Bureau of Labor Statistics tabulations for "professional & related occupations", and now hold more than 56% of such jobs. This increasing range of career opportunities has lessened women's participation in the traditional women-dominant professions of teaching and nursing, but participation by men in these fields has remained low. Male nurses account for only 8% of the national nursing workforce; in Michigan, about 8% of RNs and 6 % of LPNs are male.

Nationally, RNs held about 2.3 million jobs in 2002; they constitute the largest healthcare professional group. The job outlook for RNs is projected to be very good, with many new types of jobs emerging within nursing. "Employment of Registered Nurses is expected to grow faster than the average for all occupations through 2012...more new jobs are expected to be created for RNs than for any other occupation. Thousands of job openings also will result from the need to replace experienced nurses who leave the occupation."[14] The U.S. Bureau of Labor Statistics projects that "the number of new jobs created for RNs will increase by 27.3% between 2002 and 2012 from 2,284,000 to 2,908,000...and that total job openings due to growth and net replacements will result in 1.1 million job openings for RNs by 2012."[15]

Nationally in 2003, hospital vacancy rates for Registered Nurses were 13.5 percent, up from 13 percent in 2001; the comparable vacancy rate for Licensed Practical Nurses was 12.9 percent in 2001[16]. Additional federal projections indicate that by 2020, the U.S. nursing shortage will grow to more than 800,000 Registered Nurses[17]. National turnover rates for RNs were 15.5 percent in 2003; the overall cost of recruiting and orienting a hospital staff nurse is estimated to equal that nurse's entire annual salary, a major expense to health care employers[18]. A recent (2005) national poll of health care recruiters found a vacancy rate of 16.1 percent and an RN turnover rate of 13.9 percent[19]. See Figure 1: National Supply & Demand Projections for FTE (Full-Time Equivalent) Registered Nurses: 2000 through 2020.

To educate more new nurses, we must have additional nursing faculty. Nationally, there is a nurse faculty vacancy rate of 8.6 percent. "Nurses who teach in academic settings are aging and are not being supplemented or replaced by younger instructors. The median age of nursing instructors is about 51.1 years, and many will be retiring within the next decade."[20]

Nursing Workforce Issues in Michigan

Michigan is in the early phase of a projected 30-year shortage of professional nurses, correlated with the aging of the Baby Boom generation, which simultaneously causes a decrease in the supply of healthcare professionals and an increase in the demand for healthcare. The U.S. Census estimates that in 2030 Michigan's population will include 2,420,447 people age 65 and older, with 287,089 of those people age 85 and older[21]. Other

demand factors include population growth, the increasing intensity of care provided, and emergency preparedness needs. Supply factors include increased occupational opportunities for women, the shortage of nursing faculty to educate replacement nurses[22], and the low-prestige, high-stress image of nursing[23]. The shortage of RNs in Michigan is estimated by the Michigan Department of Labor and Economic Growth to be 7,000 nurses in 2010 and 18,000 nurses in 2015[24]. Extrapolating the 2015 supply/demand estimates provides an RN shortage estimate of 30,000 in 2020. Both the federal projections and the Michigan projections of nursing shortages are intentionally conservative, since projections are informed approximations based on current knowledge[25]. See Figure 2: Michigan Supply & Demand Projections for FTE Registered Nurses: 2000 through 2020.

Michigan nursing shortage supply factors are similar to those in the national situation, discussed above. Supply factors include problems with:

- aging of the nursing workforce – the average age of Michigan RNs is 46.1 years
- retention of the existing nursing workforce – almost 33% intend to continue practicing nursing for 10 years or less
- aging of the nursing faculty needed to educate replacement nurses -- 36% of full-time nursing faculty and 19% of adjunct faculty are age 55 or older
- retention/replacement of existing nursing faculty – 70% of institutions have difficulty filling faculty positions, with production of new faculty inhibited by the high cost (dollars, time, and energy) of graduate credentials, and salaries lower than those in clinical nursing
- enrollment of qualified students in all available admission slots in nursing educational programs – there were no admission slots for 2,097 qualified applicants in 2002/3
- retention, graduation and licensure of admitted nursing students – nursing graduates decreased from 4,260 in 1997/8 to 3,951 in 2002/3[26].

Subsidiary supply factors slow down the educational process, and delay entry of new nurses into the field. Subsidiary supply factors include shortages of:

- clinical faculty and clinical opportunities for nursing students – 45% of institutions lack enough clinical placement sites and/or clinical preceptors for students; and
- nursing education infrastructure, including classrooms, meeting rooms, learning laboratories, simulation technology, and other teaching tools.

Diversity of Nursing Workforce

An important supply factor that also relates to healthcare access and quality is the need to increase the ethnic, cultural, and gender diversity of the nursing workforce. The population of the country (and Michigan) has become more diverse, and "it is important to have healthcare delivered by nurses who are representative of the population and skilled in providing culturally competent care. African-Americans (14% of Michigan's population, 5.5% of nurses) and Hispanics (3.6% of Michigan's population, 1% of nurses) are under-represented in Michigan's nursing workforce. Asians/Pacific Islanders (2.2% of Michigan's population, 3.4% of nurses) and American Indians/Alaskan Natives (.5% of Michigan's population, 1% of nurses) are slightly over-represented in Michigan's nursing workforce[27]. The most significant under-representation is of men, who comprise about 50% of the population, but only 8% of the nursing workforce in Michigan and the nation. Intensive, long-term recruitment and retention efforts are needed to increase workforce diversity.

Figure 1 National Supply & Demand Projections for FTE Registered Nurses: 2000 through 2020

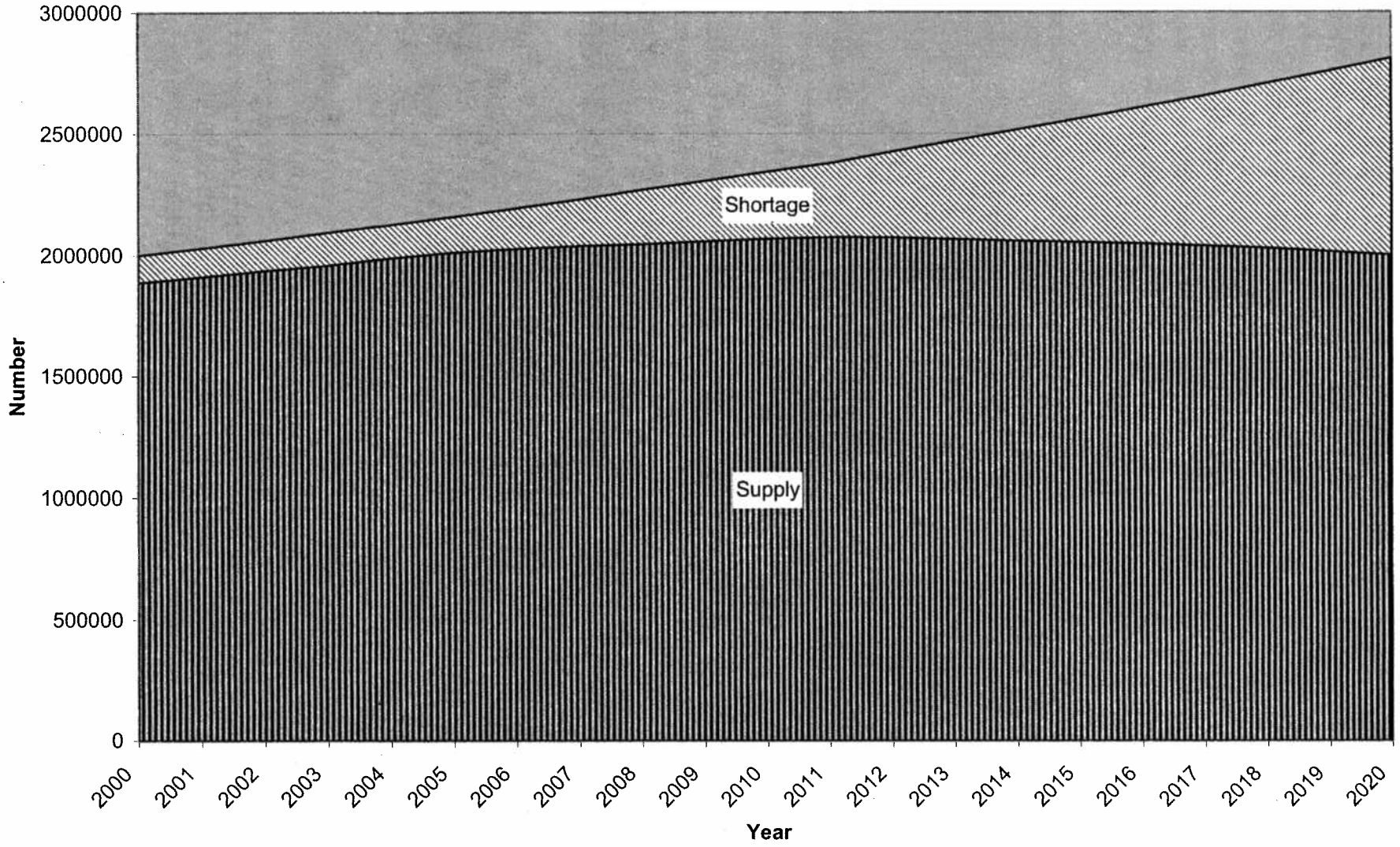
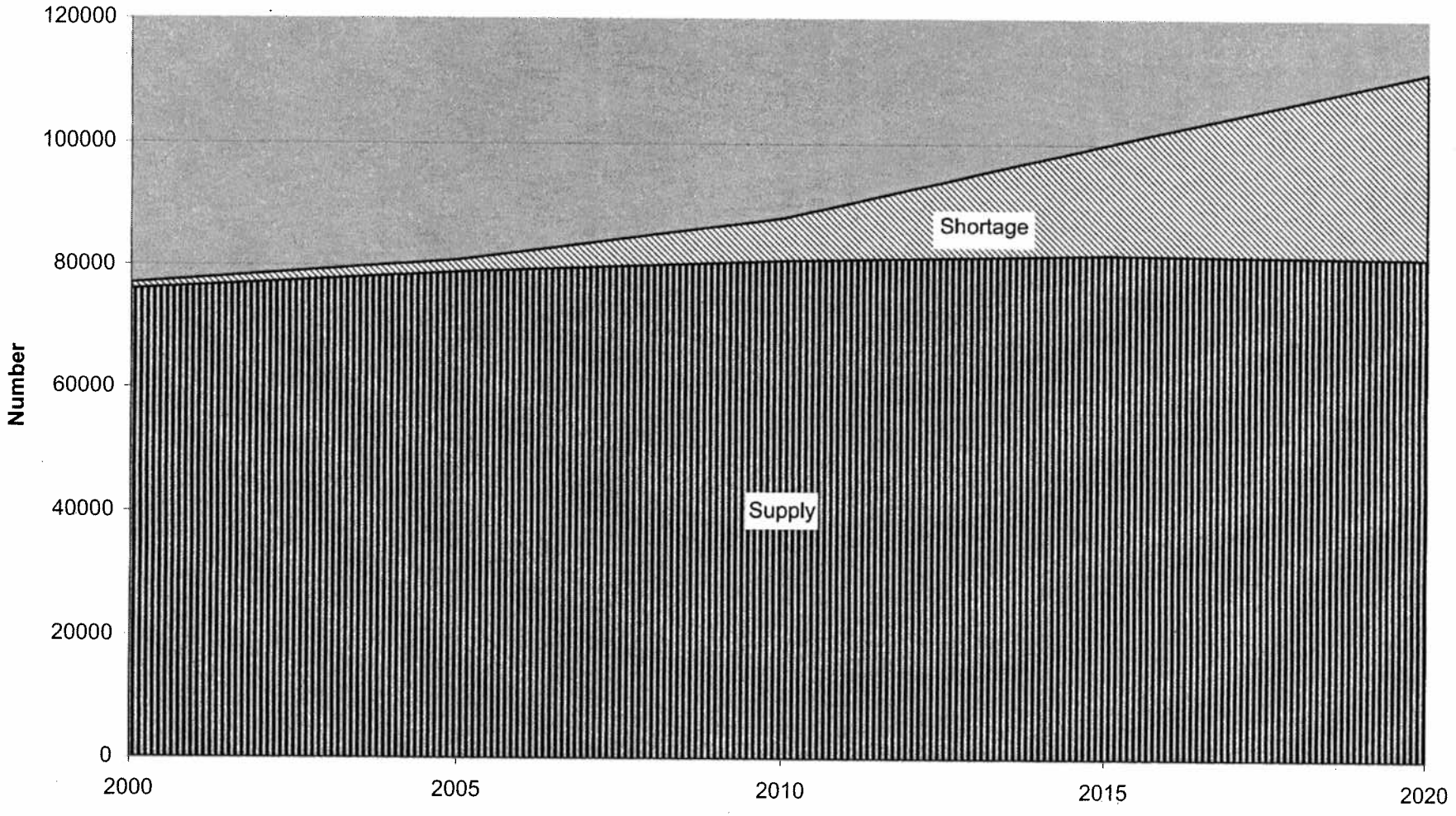


Figure 2 Michigan Supply & Demand Projections for FTE Registered Nurses: 2000 to 2020



Note: 2020 estimates are extrapolated from 2015 estimates.

Examples to Guide Action in Michigan

The short-range, mid-range, and long-range Nursing Agenda Recommended Actions cluster into four major groups: Work changes (workforce, work environment and work design); Education program changes; Healthcare system changes; and Regulatory & licensure changes (see Chapter 2 and Appendix B). All of the Nursing Agenda Recommended Actions require simultaneous attention, since all are linked in the development of a healthy population and a healthy nursing economy for Michigan.

Before we look at the Recommended Actions in detail, we must acknowledge the progress already made in improving the nursing workplace environment and organizational culture. The Magnet Hospital Recognition program (administered by the American Nurses Credentialing Center) has begun to make a difference nationally and in Michigan. Magnet hospitals provide examples and guidance that we can use in implementing the Nursing Agenda (see http://www.nursingworld.org/ancc/magnet/facilities.html).

Magnet hospitals have higher rates of nurse satisfaction, lower turnover rates, and lower nurse vacancy rates than other hospitals. Characteristics of Magnet hospitals include: excellent patient outcomes, culturally diverse staffing, culturally competent patient care, practice models characterized by a high degree of nurse autonomy and control over practice, good communications between nurses and physicians, and strong nursing leadership[28,29] Other categories of nurse employers -- clinics, home health services, public health nursing services -- also have used national models and best practices to improve the nursing workplace.

As we implement the Nursing Agenda Recommended Actions, we always must seek to use national models and best practices. The Michigan effort to avert a nursing workforce crisis should make use not only of national resources, but also of the work of the Michigan Center for Nursing, particularly in acquiring and reporting nursing data and promoting nursing excellence (see www.michigancenterfornursing.org).

Chapter 2: What Can We Do About This Nursing Crisis?

Short-range Recommendations: 1-2 years

[After each recommendation are numbers for the related segments of the Action Plans in Appendix B; for example, to find 3.2.2 look under Section 3, Issue 3.2.

Work Changes:

- Promote safe working hours to improve both patient and nurse safety and nurse retention. (Section 3.1.1)
- Improve the organization and design of nursing tasks to make them more efficient and effective. (Sections 2.1.1; 3.2.1, & 3.2.3)
- Improve the ergonomics of nursing tasks to improve the health and safety of patients and nurses. (Section 3.2.2)
- Increase shared decision-making to improve nursing input to patient care and safety. (Sections 2.1.2 & 3.2.1)
- Create a more respectful and supportive nursing workplace to improve retention of the existing nursing workforce. (Sections 1.1.3, 1.1.4, 1.1.5, 1.2.1, 2.2.1, 2.2.2, & 2.2.3)

Nursing Education Changes:

- Add additional faculty by increasing slots in fast-track master's programs, and recruiting faculty from clinical nursing and from both clinical and faculty retirees. (Sections 4.1.1, 4.2.5, & 5.1.5)
- Tap into underutilized faculty capacity to increase the number of nursing student slots available each year. (Section 4.1.1)
- Add new nurses to the workforce by increasing the number of student slots available in second-degree accelerated nursing programs. (Sections 4.2.1 & 1.4.1)
- Maximize the use and availability of web-based instruction and other technologies in nursing education. (Section 4.1.2)

Healthcare System Changes:

- Improve nurse retention through improved work design and work environment changes. (Sections 1.2.1, 1.3.2, 2.1.1, 2.1.2, 3.1.1, 3.2.1, 3.2.2, & 5.1.5)
- Improve nursing retention through improved workplace and nursing career supports. (Sections 1.1.1, 1.1.3, & 3.2.1)
- Set up collaborative multidisciplinary teams to manage & deliver patient care and increase shared decision-making. (Sections 2.1.1, 2.1.3 & 3.2.1)

Regulatory and Licensure Changes:

- Increase the outreach and responsiveness of the regulatory apparatus, so that licensure is not delayed. (Sections 5.1.1 & 6.2.1)
- Increase mentoring, support, and oversight for all stages of nursing careers, from student to retirement, by recruiting and supporting qualified retired nurses in a multitude of roles. (Sections 5.1.5 & 6.2.1)
- Use an increased nursing licensure fee to assist the nursing workforce. (6.2.1)

Mid-range recommendations (2-3 years)

[After each recommendation are numbers for the related segments of the Action Plans in Appendix B; for example, to find 3.2.2 look under Section 3, Issue 3.2.]

Work Changes

- Create the Michigan Healthcare Institute to change workplace culture and increase shared decision-making. (Sections 2.1.1 & 2.1.2)
- Increase workplace mentoring and other supports to improve nurse retention. (Sections 1.1.1, 3.1.2, 3.2.1, & 5.1.5)
- Identify areas for nursing task expansion and nursing task delegation to improve nursing practice. (Sections 3.2.3 & 6.1.3)

Nursing Education Changes

- Increase financial and other supports required to educate, recruit & retain additional nursing faculty. (Section 4.1.1)
- Increase economic, academic, and living supports needed to recruit and retain qualified nursing students. (Section 1.1.1, 1.1.2, 1.3.2, 1.4.1, 4.2.1, 4.2.2, 4.2.3, 4.2.4, 4.2.5, 5.1.4, & 5.1.5)
- Create a common curriculum for Associate's Degree in Nursing (ADN) programs statewide to improve the ADN graduation/licensure rate and quality. (Section 4.1.2)
- Ensure seamless movement from ADN to Bachelor of Science in Nursing (BSN) programs statewide to improve the BSN graduation/licensure rate and quality. (Section 4.2.1)
- Increase staff development & career education programs to improve nurse retention and improve capacities. (Sections 1.1.3 & 4.1.1)
- Promote a succession of careers in nursing for each nurse to improve nurse retention and improve capacities. (Sections 1.1.3, 1.1.4, & 4.1.1)

Healthcare System Changes

- Change organizational culture to improve nurse retention and quality of care; use selected hospitals as laboratories for change. (Section 3.2.1)
- Use mentors, and support for career & role development to improve nurse retention. (Sections 1.1.4, 2.2.1, & 3.2.1)
- Invoice nursing services as billable hours to improve the organizational culture and the image & value of nursing. (Sections 1.3.2 & 5.1.4)

Regulatory and Licensure Changes

- Create Nursing Credentials & Terminology Commission to improve consistency & quality of terminology and credentials for nursing categories. (Section 6.1.1)
- Create Nursing Education & Practice Standards Commission to ensure quality of standards for nursing education programs and nursing practice. (Section 6.1.2)
- Review Public Health Code and recommend changes to modernize the nursing-aspects of the Code. (Sections 6.1.1 & 6.1.3)

Long-range Recommendations: >3 years

[After each recommendation are numbers for the related segments of the Action Plans in Appendix B; for example, to find 3.2.2 look under Section 3, Issue 3.2.]

Work Changes

- Innovate work design & ergonomic changes to improve nurse retention and the nursing economy. (Sections 3.1.1 & 3.2.2)
- Innovate work environment changes to improve nurse retention and the nursing economy. (Sections 2.1.1, 2.1.2, 3.1.1, & 3.2.1)
- Raise the image of nursing as a profession to improve nurse recruitment, retention, & quality. (Sections 1.3.1, 1.3.2, 2.1.2, 4.2.2, 5.1.1, & 5.1.3)
- Improve the status of nursing as a revenue center to improve nurse recruitment, retention, & organizational culture. (Sections 1.3.2 & 5.1.4)

Nursing Education Changes

- Innovate faculty preparation systems to improve Michigan's percentage of graduate-degree faculty. (Sections 3.1.2 & 4.1.2)
- Innovate student recruitment & retention approaches to improve graduation/licensure numbers and rates. (Sections 1.1.2, 1.3.1, 1.4.1, 3.1.2, 3.2.1, 3.2.2, 3.2.3, & 4.2.2)
- Set up Regional Education Centers (share cutting-edge teaching/clinical technology) to improve student retention/graduation/licensure numbers & rates. (Section 4.2.5)
- Use electronic (Virtual Reality, web-based) education systems to extend the reach of education programs and increase educational capacities. (Sections 4.2.5 & 4.3.2)

Healthcare System Changes

- Expand national-standard electronic information systems to improve efficiency, quality of care, and nurse retention. (Section 3.2.4)
- Innovate nursing life-career supports to improve nurse retention. (1.1.4 & 2.2.1)
- Institutionalize nursing as a revenue center to secure the status of nursing as a profession and improve nurse recruitment & retention. (Sections 1.3.2 & 5.1.4)

Regulatory & Licensure Changes

- Institute a continuous quality improvement process (CQIP) for nursing regulatory policies & procedures to improve the responsiveness of the system to the needs of nurses and nurse employers. (Sections 3.2.1 & 6.2.1)
- Expand data collection, analysis, and reporting to inform nursing & health policy. (Sections 1.3.1 & 6.2.1)
- Enact Public Health Code recommended changes for nursing to prepare Michigan for the challenge of the next thirty years in healthcare. (Sections 6.1.1, 6.1.2, & 6.2.1)
- Engage the nursing community for policy input on a continuing basis to ensure that nursing systems adjust to a changing environment. (Sections 1.3.1, 6.1.1, & 6.2.1)

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Chapter 3: What Will These Changes Accomplish?

Improve the Health of Michigan's People

Nurses are a critical component of the healthcare system, and provide the majority of patient care in virtually all health care settings. Nurses improve patient care and safety in hospitals, and provide direct care nursing, preventive care, health education, and public health, mental health, and occupational health care in a variety of settings. Nurses keep people well throughout the lifespan (immunizations, school nursing, diabetes education, etc.). This increases the number of healthy, productive people in the workforce overall.

Nurses improve the effectiveness and efficiency of the healthcare system by providing care/case management and disease management (to make sure that patients get the right care at the right time from the right provider). Nurses teach people what they need to know for self-care and self-care management (how to deal with the system). This approach to healthcare is becoming more common as health insurance covers less care, and our aging population requires more care.

Professional nurses will become even more important in the provision of healthcare as an aging population increases the demand for healthcare over the next thirty years, the wide range of healthcare services provided by nurses become more important, our country must deal with health threats from both socio-political and natural sources, and the funding of healthcare becomes even more problematic.

Implementation of the Michigan Nursing Agenda Recommended Actions will:
first, help us keep the nurses we already have by improving the work environment, the safety of the work itself, and the respect and support provided to nurses[30];
second, help us add new nurses to the workforce by increasing the number of nursing faculty and students, and improving the image of nursing;
third, help us understand both the healthcare and economic roles of nursing in Michigan;
fourth, strengthen the nursing profession and nursing standards of practice in Michigan, so that we can maintain high quality care, increase respect for nursing as a profession, and create an arena in which nursing can adapt to the needs of the population; and
fifth, help us increase the ethnic and cultural diversity of the Michigan nursing workforce, so that it reflects the ethnic and cultural diversity of the state population and thereby improves patient access to care and patient outcomes.

Improve the Health of Michigan's economy

The business case for nursing is made in the 2004 and 2005 *Economic Impact of Health Care in Michigan* reports from the Partnership for Michigan's Health[31]. Healthcare is Michigan's largest single employer, providing over 472,300 direct jobs, plus 254,340 indirect/induced jobs. The average healthcare employee earns $34,300 per year and contributes $55,000 to the local economy in direct and indirect/induced spending. Nurses are the largest licensed group of healthcare professionals, and have above average compensation. Therefore, each nursing position is worth a minimum of $55,000 per year, and the 90,470 nurses working in direct patient care jobs in 2004 brought a minimum of $5 billion into local and state economies.

Each unfilled nursing position constitutes a substantial economic loss to local and state economies. The number of unfilled nursing positions (vacancies) statewide in 2004 is estimated to range from almost 12,000 to over 14,000, based on the number of licensed nurses providing direct patient care and national vacancy rates[32]. This has a negative effect on patient care and safety, increases stress on the nurses caring for patients, and means that local and state economies have suffered a minimum estimated loss of $660 million over the past year. The Nursing Agenda Recommended Actions will help to fill those nursing vacancies, improve patient and nurse safety, and increase the economic benefit of nursing to local and state economies.

As the Nursing Agenda for Michigan is implemented, innovations in nursing ergonomics, healthcare design, facilities design, and healthcare organization can be marketed widely. Michigan's innovations in nursing products and services can be leveraged to increase national and international sales. Organizational, educational, funding and regulatory changes will also ensure that Michigan's healthcare dollars are invested in Michigan for Michigan's future.

The nation and the State make a huge investment in healthcare every year. Shouldn't Michigan's healthcare investment be targeted within Michigan to improve Michigan's healthy economy and healthy future?

The complete Nursing Agenda for Michigan is available online at:
www.michigan.gov/mdch/ocne

End Notes

[1] Rothert, M., Wehrwein, T., & Andre, J. (2002) .*Nursing Workforce Requirements for the Needs of Michigan Citizens* in "Informing the Debate: Health Policy Options for Michigan Policymakers", IPPSR, Michigan State University, East Lansing, Michigan.

[2] The practice of nursing is regulated by the Occupational Regulations of the Michigan Public Health Code. These regulations require that nursing care be provided under the supervision of a Registered Nurse. Without adequate numbers of professional registered nurses, healthcare systems cannot function. Other roles of professional nurses include: nursing leadership and management (nurses define standards of nursing care and practice, develop policies and procedures in health care settings); nurse-executives (chief executive nurses oversee the operations of nursing services, nurses serving as chief operating officers oversee the operation of clinical services delivered in healthcare settings); nurse educators (nurses provide patients and staff education, ensure that health care personnel receive orientation to new jobs, or updates in current health care practices). Advanced practice nurses (with a masters degree in nursing), Clinical Nurse Specialists, and Nurse Practitioners are all Limited independent Practitioners who specialize in an area of nursing practice. [Michigan Public Health Code and communication from Michigan Mental Health Nursing Directors.]

[3] Michigan Department of Labor & Economic Growth (2004). *The Health Care Sector and Michigan's Economy:* p.26.

[4] Michigan Center for Nursing (2005). *Survey of Nursing Education Programs: 2002-2003 School Year.*

[5] It is interesting and significant that the US Department of Labor still lists nursing and teaching under the "Women's Bureau".

[6] Bureau of Labor Statistics, U.S. Department of Labor, *Occupational Outlook Handbook, 2004-5 Edition,* Registered Nurses, on the Internet at http://www.bls.gov/oco/ocos083.htm.

[7] Michigan Department of Labor & Economic Growth (2004). *The Health Care Sector and Michigan's Economy:* p.47.

[8] Kalisch, Bea. *The Image of Nursing: Evolution and Revolution.* Sigma Theta Tau International, Rho Chapter, University of Michigan New & Events, 2000.

[9] *Crisis in Nursing has its roots in an image problem,* Seattle Post-Intelligencer, September 3, 2000.

[10] Public health nurses and other community-based nurses express concern about low compensation and respect levels, but also express pride in their greater autonomy, and less difficulty in recruitment and retention for positions in their fields. [Communication from MALPH Public Health Nurse Administrators Forum.]

[11] U. S. Bureau of Labor Statistics (2005). *Women in the Labor Force: A Databook.*

[12] Heylin, M (2005). Evolving anatomy of the U.S. Labor Force, *Chemical & Engineering News,* June 13, 2005: 17-20.

[13] Ibid.

[14] Bureau of Labor Statistics, U.S. Department of Labor, *Occupational Outlook Handbook, 2004-5 Edition,* Registered Nurses, on the Internet at http://www.bls.gov/oco/ocos083.htm

[15] http://www.dol.gov/wb/factsheets/Qf-nursing.htm.

[16] Michigan Department of Labor & Economic Growth, October 2004. *The Health Care Sector and Michigan's Economy:* pp 8-9

[17] Health Resources and Services Administration, Bureau of Health Professions (2002). *Projected Supply, Demand and Shortages of Registered Nurses: 2000-2020.* Washington, DC: U.S. Department of Health & Human Services.

[18] Michigan Department of Labor & Economic Growth (2004). *The Health Care Sector and Michigan's Economy:* p.10.

[19] http://www.aacn.nche.edu/Media Fact Sheets/NursingShortage.

[20] Michigan Department of Labor & Economic Growth (2004). *The Health Care Sector and Michigan's Economy:* p.38.

[21] United States Census: Population Projections by State. [See: http://www.census.gov.]
[22] Rothert, M., Wehrwein, T., & Andre, J. (2002).*Nursing Workforce Requirements for the Needs of Michigan Citizens* in "Informing the Debate: Health Policy Options for Michigan Policymakers", IPPSR, Michigan State University, East Lansing, Michigan.
[23] Ibid, p13.
[24] Michigan Department of Labor & Economic Growth (2004). *The Health Care Sector and Michigan's Economy:* p. 26, plus projections drawn from federal sources (see above).
[25] All Michigan projections are rounded to the nearest thousand, since projections are necessarily approximations. The extrapolation of 2015 projections to 2020 takes into account a slight drop in nursing supply due to Baby Boomer Retirements (compare to federal projections), Michigan's generally low rate of population increase, and the effect on demand of the aging Baby Boomers (about half of whom will be retired by 2020). Keep in mind that all projections are approximate, and unpredictable factors (environmental, demographic, economic, technological, & socio-political) may render projections unreliable. Shortage projections should be updated as circumstances change.
[26] All data are taken from recent reports of the Michigan Center for Nursing. See http://www.michigancenterfornursing.org and http://www.mhc.org/mhc_images/surveyfinalreport.pdf.
[27] See Rothert, M., et al (2002). Ibid, p 9. The figures given in the Nursing Agenda text are for 2004; Michigan population figures are from the U.S. Census 2004 estimates, nursing estimates are from the Michigan Center for Nursing, *Survey of Nurses 2004*. Comparable 2004 figures on the national level are: African-Americans (12.1% general population, 4.9% Registered Nurses) and Hispanics (12.5% general population, 2% Registered Nurses). Results from the Michigan Center for Nursing *Survey of Nurses 2005* are for Michigan licensed nurses actively working in the field of nursing: For active Registered Nurses (6% African-American, 4% Asian/Pacific Islander, 1% American Indian/Alaskan Native, and 1% Hispanic); for active Licensed Practical Nurses (13% African-American, 2% Asian/Pacific Islander, 1% American Indian/Alaskan Native, and 1% Hispanic).
[28] American Nurses Credentialing Center website: http://www.nursingworld.org/ancc/magnet.
[29] Examples of Michigan hospitals and healthcare systems holding or seeking Magnet hospital status include: Henry Ford Health System, St John Health, Trinity System (Mercy General Health Partners), Ascension System, and others whose goals align with the Magnet program.
[30] *The Nursing Agenda for Michigan* should be used by nurses as a source of ideas for workplace and workforce improvement in their various work environments, and in strategic planning. *The Nursing Agenda for Michigan* also should be included in senior and graduate nursing courses at colleges/schools of nursing, to stimulate critical thinking, creativity, and interest in health policy and the Future of Nursing. [Communication from Ada Sue Hinshaw, PhD, RN, FAAN, Dean, University of Michigan School of Nursing.]
[31] The Partnership for Michigan's Health includes the Michigan State Medical Society, the Michigan Health & Hospital Association, and the Michigan Osteopathic Association.
[32] Michigan Department of Labor & Economic Growth (2004). *Health Care Workforce Development in Michigan.* and the Michigan Center for Nursing, *Survey of Nurses 2004* and *Survey of Nurses 2005.*

Appendix A

Nursing Agenda Development: Process and Participants

Process of Developing the Nursing Agenda for Michigan

The Coalition of Michigan Organizations of Nursing (COMON) was organized in 1984. In 2002, responding to a worsening nursing shortage, COMON started documenting nursing issues; and in 2004, in cooperation with the office of the Michigan Chief Nurse Executive, COMON member organizations sent representatives to work on development of a Nursing Agenda for Michigan. Following roundtable discussions in late 2004 and early 2005, six topic-specific committees worked intensively to identify issues and action steps to be recommended to Governor Granholm. These action steps are presented in Appendix B as tables, which include issue statements, recommended actions, responsible parties, timelines, and action indicators.

The complete Nursing Agenda for Michigan reviews the issues, presents the recommended actions, and summarizes outcomes. The policy makers and people of Michigan are asked to carefully consider and act upon the recommended actions. The participants (see list below) in the Nursing Agenda development process appreciate your willingness to listen and your concern for Michigan's future health care resources and economy.

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Other Organizations Endorsing the Nursing Agenda for Michigan

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Michigan Department of Labor and Economic Growth
Michigan Health Council
Michigan Home Health Association

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Appendix B

Nursing Agenda Recommended Actions

Overview

The health and safety of patients requires an adequate supply of high-quality professional nurses. Most healthcare consumers and health policy makers are aware of at least some nursing workforce issues – shortages, recruitment difficulties, retention difficulties, and education shortages. In general, recruitment and retention of professional nurses require that nurses be treated as respected professionals whose input is effective. The Nursing Agenda Recommended Actions cover the generation, recruitment and retention of a high-quality, diverse, well-educated nursing workforce operating in an innovative work environment that is patient-centered and supportive of nursing. The Coalition of Michigan Organization of Nursing has worked to develop the Nursing Agenda and recommends the following actions:

Implement the Actions recommended in **Nursing Agenda Section 1, Workforce,** to improve retention of the nurses Michigan already has in the workforce. Workforce issues are central to all discussions of the nursing shortage. These issues connect to all the other recommendations.

Implement the Actions recommended in **Nursing Agenda Section 2, Work Environment,** to create a supportive work environment, improve collaborative decision-making and patient health outcomes, and retain more of the professional nurses currently working in the field, thereby increasing the workforce.

Implement the Actions recommended in **Nursing Agenda Section 3, Work Design,** to improve patient and nurse safety, and the efficiency and effectiveness of nursing tasks. This section considers the ergonomics and organization of nursing work, and recommends far-reaching improvements to improve patient safety and retain more of the professional nurses currently in the nursing workforce.

Implement the Actions recommended in **Nursing Agenda Section 4, Nursing Education,** to improve the short-term, mid-term, and long-term supply of Michigan nursing faculty, leaders, and nurses. Without adequate numbers of well-prepared faculty and leaders, we cannot expect to increase the number of well-prepared nursing graduates. This section recommends actions to add faculty and educate new nurses to increase the nursing workforce.

Implement the Actions recommended in **Nursing Agenda Section 5, Economic Impact of Nursing,** to ensure that healthcare consumers, employers, and policy makers are aware of the role of nurses in the provision of quality health care, and in the maintenance and improvement of the Michigan economy. Improving the nursing workforce will improve the economy of the state, as well as the health and safety of patients.

Implement the Actions recommended in **Nursing Agenda Section 6, Scope of Nursing Practice,** to strengthen the nursing profession and standards of practice. Patient health and safety require that nursing standards and appropriate scope of nursing practice be strengthened. We must maintain high quality care and increase respect for professional nurses while increasing the nursing workforce.

In all of these activities, we recommend that emphasis be placed on increasing workforce diversity. Evidence shows that a diverse health workforce, that reflects the cultural, ethnic, and gender diversity of the state population, improves both patient access to quality healthcare and patient outcomes. Increasing diversity will improve the nursing workforce and the health and safety of patients.

Nursing Agenda – Section 1 – Workforce

Issue 1.1: Retention of professional nurses requires a respectful, supportive workplace, with education, mentoring, & career development.

Issue	Recommended Action			Action Indicator
	Who	Does What	When	
1.1.1: Retention of new nurses requires that upper- & mid-level nursing managers receive education in leadership, mentorship, and modern management skills.[1] This is particularly important where there is high turnover in the Chief Nursing Officer role, and where role expectations may exceed preparation, degrees, & capacities.	CNE, Board, MCN, MHA, nurse employers, business & nursing schools/colleges, nursing organizations, business partners	Provide support and incentives for nursing leadership & management programs, workplace mentoring, and on-line resources to assist upper & mid-level nurse-leaders in improving their skills. ▪ Work with Nursing organizations, nursing schools/colleges and nurse employers to provide to diverse nurses: nurse leadership and executive/management education (interaction skills, finance, budgeting), worksite mentoring for nurse-leaders, and nursing team-building education. ▪ Provide incentives to individuals and institutions that take this path (i.e., promotion based on evidenced skills in leadership, team-building, & executive/management capacities). Work with Retired Nurses Corps (described in Section 5.4) to provide appropriate mentors.	By 2007 By 2009	Nurses (representing diverse cultures and ethnicities) and nurse employers invest in education for nurse-leadership & management, executive skills, interaction skills, team-building, & worksite nurse-leader mentoring. Nurse employers establish upper-level nurse leaders (i.e., Chief Nursing Officer) as part of top management team.
	CNE, MCN, Board, nursing schools/colleges, MHA, nurse employers, nursing organizations, partners	Establish leadership competency standards and programs for educating in nursing leadership, management, and mentoring. ▪ Work with educational institutions and the Board of Nursing to identify certification standards and model education programs in nursing leadership, management, & mentoring. ▪ Emphasize the relationship among nursing leadership, management skills, and high-quality patient care[2]. ▪ Offer education to a diverse group of nurses through a variety of channels, including on-line courses.	By 2007 By 2008	Certification standards & education programs are in place. On-line courses are available.

Nursing Agenda – Section 1 – Workforce

Issue 1.1: Retention of professional nurses requires a respectful, supportive workplace with education, mentoring, & career development.

Issue	Recommended Action			Action Indicator
	Who	Does What	When	
1.1.2: Nursing retention requires that new graduates receive worksite education and mentoring. **(See Nursing Agenda Section 4, Nursing Education for additional recommendations.)**	CNE, Board, MCN, MHA, nurse employers, nursing organizations, nursing Schools, partners	Provide support and incentives for nurse-internship/residency and nurse-mentor programs in the workplace. ▪ Work with nursing organizations, nursing schools/colleges and nurse employers to make the case for and provide: post-graduate internships/residencies in which new nurses rotate through units, learn collaboration with teams of nurses & multidisciplinary teams, and focus on patient-centered care[3]. ▪ Work with nursing organizations, nurse employers, and the Retired Nurses Corps (see Section 5.4) to create nurse-mentor programs in the workplace. ▪ Establish demonstration project grants to consortia of hospitals and educational institutions. Test models for nursing internships/residencies and mentoring[4]. Disseminate best practices. ▪ Provide incentives to individuals and institutions that establish nursing internships/residencies and nurse-mentor core-competency programs. Encourage Regional Alliances to support programs. ▪ Pay nursing interns/residents to provide care. ▪ Evaluate mentors on the success of their interns/residents. ▪ Evaluate institutions on decreased turnover and recruitment costs.	By 2007	Nurses and institutions invest in nursing internship/residency programs and staff nurse mentoring programs; retention rates improve; turnover and recruitment costs decrease.

Nursing Agenda – Section 1 – Workforce

Issue 1.1: Retention of professional nurses requires a respectful, supportive workplace with education, mentoring, & career development.

Issue	Recommended Action			Action Indicator
	Who	Does What	When	
1.1.3: Nursing retention requires increased attention to career development and nursing role changes. **[See Nursing Agenda, Section 4, Nursing Education.]**	CNE, Board, MCN, MHA, nurse employers, nursing organizations, nursing schools/colleges, partners	Work with nurse-leaders and nurse employers to implement support for a flexible nursing career ladder. ▪ Set up nursing career development teams including nurse-leaders (administrators & managers) & Human Resources staff to: evaluate employees for career development; support employee career choices; & partner with external resources. o Improve nurse-to-nurse communication around career development. o Provide opportunities for professional growth & development, including release time and other resources. o Create an environment supportive of research-based and evidence-based practice; consider public health example. o Provide opportunities for role "shadowing" & career sampling to support nursing interest in a role change (and thereby increase retention)[5]. o Provide interprofessional interaction education for physicians, nurses, pharmacists, etc.; improve collaborative teams, retention & patient care; expand nursing career roles.[6] o Provide support for e-testing, e-learning, and the acquisition of new competencies/certifications. o Provide support for career transitions.	By 2007 By 2009	Nurses & nurse employers invest in career development; retention rates improve; turnover & recruitment costs decrease. Nurses, nurse employers, & other health professionals invest in interprofessional interaction education; retention rates improve; range of nursing career roles expands.

Issue 1.1: Retention of professional nurses requires a respectful, supportive workplace with education, mentoring, & career development.

Issue	Recommended Action			Action Indicator
	Who	Does What	When	
	CNE, Board, MCN, MHA, nurse employers, nursing organizations, nursing schools/colleges, partners	Provide support for role changes & specializations that may be related to experience and capacities, rather than education [i.e., direct-care career track, case/care manager, preceptor/mentor, home health manager, etc.]. Recognize, reward & retain experienced nurses in direct-care nursing by: ▪ Creating a direct-care career track (i.e., progressive movement to less physically demanding variants of direct-care nursing, including mentoring, care/case management, & leadership[7]) that appropriately rewards experienced nurses who wish to remain in direct-care nursing. ▪ Increasing scholarships, stipends, & loan-forgiveness for nurses in these programs, so that direct-care career track nurses can work part-time while completing additional degrees and certifications.	By 2007	Experienced direct-care nurses are retained in direct-care nursing through career development and education supports
1.1.4: Nursing retention requires support for maintenance & improvement of nurses' physical & mental health status.	Nurses, CNE, MDCH, Surgeon General, nursing organizations, nurse employers, partners	Expand nurses' lifetime career planning to include proactive approaches (exercise facilities, EAPs, support groups) to the maintenance of physical & mental health throughout a stressful career. Educate & support nurses, nurse administrators, & nurse employers in following this path. ▪ Expand nurses' health initiatives by building upon the Michigan Surgeon General's programs in collaboration with the Chief Nurse Executive. ▪ Link stress-reduction, tobacco control, and incentives; improve nurses' health & retention.	By 2008	Programs to maintain & improve nurses' health status are in place and funded. Nursing retention is improved.

Issue 1.1: Retention of professional nurses requires a respectful, supportive workplace with education, mentoring, & career development.

Issue	Recommended Action			Action Indicator
	Who	Does What	When	
1.1.5: Nursing retention requires support for maximizing use of the functional abilities of nurses with temporary/permanent disabilities or physical limitations.[8]	CNE, OFIS, MCN, MHA, nurse employers, public & private workers' compensation agencies, nursing schools/colleges	▪ Explore possibility of increasing the percentage of injured/disabled nurses who return to work by changing employers'/insurers' approach to rehabilitation in nursing Workers' Compensation cases. o Collect, analyze, & report information on rehabilitation of nurses with disabilities or physical limitations. Educate nurses, nurse employers and their insurers on approaches that increase rehabilitation and return to work in appropriate work categories. Utilize on-line certificate programs and other education programs that create new skills to enable nursing workforce participation. Compare cost of rehabilitation to cost of recruitment.	By 2007/8 By 2007	Rehabilitation increase report disseminated. Nurses, nurse employers & their insurers are educated about rehabilitation approaches and costs.

Nursing Agenda – Section 1 – Workforce

Issue 1.2: Retention of professional nurses requires investment in existing staff and compensation equity.

Issue	Recommended Action			Action Indicator
	Who	Does What	When	
1.2.1: Retention of nurses requires investment in existing nursing staff to increase nurse satisfaction and nurse & patient health & safety[9]. Such investment should include support of staff education & advancement, plus equitable compensation and treatment. **[See Section 1.4.1 for further discussion of investment.]**	CNE, Board, MCN, MHA, nurse employers, nursing organizations, nursing schools/colleges, partners	Increase nurse employer investment in existing nursing staff through support for education, advancement, and compensation. Ensure that nurse employers maintain equity between compensation/benefits offered to existing nursing staff and new/contract nursing staff. ▪ Work to ensure equitable & competitive levels of compensation and benefits for both new/contract and existing staff. o Reward both new/contract & current staff for educational attainment, credentials, years of service, and performance improvement. o Support ADN graduates in their efforts to attain BSN nursing degrees. o Compare equitable compensation and benefits to cost of increased turnover. ▪ Discontinue practices that are disincentives to existing nursing staff (new/contract staff signing bonuses or high hourly rates, career development benefits, and other benefits not offered to current nursing staff). ▪ Encourage use of recruitment & retention best practices (Magnet hospitals) and national models.	By 2008	Nurses & nurse employers see increasing investment in existing nursing staff and decreasing dependence on contract staff. Nurses see greater equity between new/contract and current nursing staff. Patient & nurse health & safety improve; retention rates improve; recruitment & turnover costs decrease.

Nursing Agenda – Section 1 – Workforce

Issue 1.3: Recruitment & retention of nurses require that the image of the field be improved and nurses be considered professionals.

Issue	Recommended Action			Action Indicator
	Who	Does What	When	
1.3.1: Policy makers and the public do not have an accurate picture of nurses or nursing as a profession.	CNE, Board, COMON, MCN, MHC, MHA, nurse employers, nursing organizations, nursing schools/colleges, media & other partners	Improve the image of the nursing profession by: ▪ Engaging in a statewide education campaign (targeting policy makers, the public, and practicing nurses) to: o **Encourage nurses to think & speak positively about their profession.** o Create Nurse Champions to educate others. o Encourage nurses to join professional organizations to increase professionalism, increase networking, and elevating the image of nursing. o Show nurses as professionals in a wide range of roles and venues with good salaries and benefits. o Show the diversity of nurses, including multiple ethnicities/races, males/females, and a range of education/work histories. o Show the roles and responsibilities that nurses currently have and are likely to have in the future. o Emphasize the educational background required for a successful nurse, including emphasis on science and mathematics. ▪ Presenting this information through a wide range of channels, including video, print, and web-based formats.	By 2007	Education campaign elements are in place.

Issue 2.2: Some aspects of work compensation are inadequate for retention of professional nurses.

Issue	Recommended Action			Action Indicator
	Who	Does What	When	
2.2.2: Many nurse employers do not offer access to retirement health insurance coverage.	CNE, Nursing Organizations, MCN, MHA, OFIS	Recognize the merit of making available to retiring nurse-employees the right to buy-in to employer-sponsored health insurance. ▪ Make the business case for employee & employer investment in health insurance buy-in plan; compare cost of buy-in plan with cost of recruitment. ▪ Index employer buy-in plan contribution to nurse period of employment (retention tool). ▪ Educate nurses, managers, & CEOs on the benefits of health insurance buy-in plans, particularly for nurses who retire early due to job-related injuries. ▪ Explore feasibility of statewide or regional approaches to retirement health insurance for all healthcare professionals, including nurses (purchasing cooperatives, pools, etc.).	By 2008 By 2007	Health insurance buy-in plans available to retiring nurses statewide; nurses, managers, & employers are trained on benefits of buy-in plans; employer contribution increases with nurse period of employment. Work with experts in both insurance and labor to develop a feasibility study and recommendations
2.2.3: Many existing nurse-employer benefit structures lack the flexibility needed to recruit and retain nurses.	CNE, MCN, Nursing Organizations, MHA, OFIS	▪ Collect, analyze, & report information on nurse utilization of extant cafeteria benefit plans. ▪ Explore the feasibility of a statewide cafeteria benefit plan for nurses to permit a flexible relationship between individual needs and allocation of benefits.	By 2007 By 2008	Cafeteria benefit plan utilization report is disseminated. Feasibility report is disseminated.

[1] "Interprofessional focus" describes an approach to collaboration and interaction among all the health professionals and administrative professionals in a healthcare provider organization. "Shared governance" has been used in nursing terminology to express much the same approach, with an emphasis on a) multidisciplinary teams to make decisions on patient care and b) shared administrative decision-making for the organization as a whole.

[2] The Michigan Health & Hospital Association Foundation provides educational programs for a number of health professions. The MHAF could serve as a dissemination channel for educational modules developed under this Recommended Action.

[3] See *Ideas for Achieving Higher Reliability in Healthcare* at http://healthcare.isixsigma.com. A barrier to achieving "high reliability status in healthcare organizations" is that the healthcare industry is based on "21st century technological and clinical advances stuck in 20th century workflow and management systems." Some large Michigan hospitals and health systems have adopted innovative approaches to leadership and the implementation of best practices: for example, St John Health in southeast Michigan has educated entire hospital staff groups on the Six Sigma approach to problem solving and error reduction.

[4] The Michigan Nonprofit Association and other organizations serving Michigan nonprofits will be consulted for expertise relevant to Section 2.1.3.

[5] The extent to which such organizational change is successful may depend on the degree to which the nurse-employer CEO and senior management are connected to nursing practice and nurse-administrators in their institution.

[6] The 18-day strike of nurses at Ingham Regional Medical Center (October 12 through October 31, 2005) was focused on two issues: improvement of nurse staffing at the hospital; and improvement of nurses' pension plans. The members of Office and Professional Employees International Union Local 459 approved a new three-year contract with IRMC, and said that the battle for pension plans equal to those received by nurses at Flint's McLaren Regional Medical Center would have to wait for three years. New IRMC nursing employees will be enrolled in a defined contribution plan, similar to a 401(k). The contract increased nurses' wages between 9 and 11 percent in the first year, and between 4 and 5 percent in the second and third years (Lansing State Journal, October 31, 2005). The inference may be made that employer concern about pension costs outweighed concern about increased nurse staffing and increased nurse salaries.

[7] Several sources have suggested statewide or nationwide pension plans for nurses, modeled after public employee pension arrangements. One example is a proposal for a government-sponsored pension plan for nurses similar to that offered public safety officers; such pension plans are seen as an aid to recruitment and retention in many fields. [Leonick, L. MPA, RN. A Modern Proposal, *American Journal of Nursing*, June: 2005.]

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Nursing Agenda – Section 3 – Work Design

Issue 3.1: Nurse staffing at many health care facilities is inadequate/inappropriate for patient and nurse safety.

Issue	Recommended Action			Action Indicator
	Who	Does What	When	
3.1.1: Safe Working Hours[1] are often not the basis for decision-making on the (voluntary or mandatory) length of nursing shifts/work-weeks. High levels of nurse fatigue & stress are detrimental to the health and safety of both patient and nurse. Nurses often do not have sufficient input into staffing/scheduling decisions[2].	CNE, MCN, Nursing Organizations, MHA, Patient Safety Commission, Nurse researchers, Legislature	Set up collaborative staffing methodology to determine safe staffing per facility/service per day. Ensure appropriate nursing input into staffing/scheduling decisions through shared governance/decision-making. ▪ Utilize research findings/evidence to determine Safe Working Hours to improve both patient & nurse health & safety.[3] ▪ Develop frameworks within which nurse-employers progress from: o A) reactive staffing approaches; to o B) prescriptive methods, such as staffing ratios, etc.; to o C) flexible staffing approaches to meet the needs of patients & anticipate loads.	By 2007	Systems and information technology are in place to assist healthcare entities as they progress from reactive staffing to prescriptive staffing to flexible Safe Working Hours staffing approaches.
		▪ Use Magnet Hospital concepts[4], Best Practices to generate Safe Working Hours options. o Consider synergy model[5], in which patients' needs are matched to nurses' preparation and competency. o Develop self-scheduling guidelines.	2007	Patient & nurse health & safety are improved.
		▪ Support development of multidisciplinary councils or professional nurse councils (facility specific) to collaboratively determine staffing needs, staffing algorithms, and supportive information system software. ▪ Support research and information systems development for prediction of staffing needs on a real time basis.	2007	Professional nurses have increased input to staffing decisions through shared governance/decision-making.

Nursing Agenda – Section 3 – Work Design

Issue 3.2: The efficiency and effectiveness of many nursing work processes are poor.

Issue	Recommended Action			Action Indicator
	Who	Does What	When	
3.2.1: Work processes often are not designed to support patient-centered care or the efficiency & effectiveness of nurses.	Nursing organizations, MDCH, MHA, Patient Safety Commission, review & regulatory agencies, manufacturing and business entities, schools of business architecture, nursing, other partners, consultants	Redesign work processes for all health professionals to be focused on patient-centered care; maximize nursing efficiency & effectiveness. ▪ Develop multidisciplinary teams to collaboratively redesign work processes used by physicians, nurses, nurse aides, pharmacists, and other relevant health professionals. o Develop & provide best practices & models, (e.g., *High Reliability Organizations*[6]) to achieve focus on patient safety in the organization & planning of care[7]. o Develop & provide guidelines, tools, & templates to be used in nurse-employer entities to support work process CQIP[8].	By 2007	Healthcare researchers, healthcare stakeholders, and collaborative multidisciplinary teams redesign work processes. Tools for implementing redesigned work processes are disseminated.
		▪ Multidisciplinary teams identify necessary supports for nursing patient-centered care tasks (support staff; access to information, functioning equipment, medications, etc.). o Provide nurses and all relevant care staff (on all shifts) with access to appropriate clinical care supports (staff, information, functioning equipment, medications, etc.). o Develop & provide guidelines, tools, & templates to be used in nurse-employer entities to support work process CQIP.	By 2007	Multidisciplinary teams identify necessary supports for nurses providing patient-centered care. Tools for implementing support system are disseminated. Nursing direct-care time increases; nursing job satisfaction increases.

Issue 3.2: The efficiency and effectiveness of many nursing work processes are poor.

Issue	Recommended Action			Action Indicator
	Who	Does What	When	
3.2.1 (cont.)		▪ Work with representatives of manufacturing industries to improve work process efficiency & effectiveness. o Develop research capacity & partnerships among schools of business and nursing, healthcare entities, business partners, and MEDC.	By 2007	Multiple business & nursing stakeholders collaborate in work process redesign.
		▪ Identify and fund hospitals/units as laboratories for work design testing and translation of research into practice. o Provide incentives to nurse-employers and nurses who follow this path.	By 2008	Selected hospitals/units test redesigned work processes.

Nursing Agenda – Section 3 – Work Design

Issue 3.2: The efficiency and effectiveness of many nursing work processes are poor.

Issue	Recommended Action			Action Indicator
	Who	Does What	When	
3.2.2: The poor ergonomics of many nursing tasks contribute to injuries & stress. The physical stress of lifting/ moving patients and equipment is injurious to the health & safety of both patients & nurses	Nursing Organizations CNE, MHA, Patient Safety Commission, MDCH, MIOSHA, Public & Private Workers' Compensation agencies, OFIS, MEDC, universities, consultants	Institute national/state guidelines on ergonomics (OSHA, AHRQ, ANA, MIOSHA, state agencies) to prevent both patient and nurse injury. Use equipment for lifting and moving patients.		
		▪ Use ergonomic guidelines, best practices and national models to develop safe lifting approaches for health care entities[9].	By 2007	Ergonomic guidelines are adopted and implemented in all Michigan nurse-employers.
		o Disseminate safe-lifting guidelines to all nurse employers and all practicing nurses through a state website, semi-annual communications, etc.		
		▪ Promote alternative approaches to moving/lifting patients. Use specialized furniture & equipment to lift/move patients.[10]	By 2008	Alternative approaches to moving/lifting patients are in place. Recruitment & retention rates are improved.
		▪ Educate all caregiver staff (nurses, physician assistants, nurses aides, porters, volunteers, etc.) on equipment-assisted lifting/moving of patients.		
		▪ Work with educational institutions to ensure that nursing faculty, allied health faculty, and students in these fields receive this instruction as a component of curriculum.	By 2008	Education programs on assisted lifting/moving of patients are widely available in worksites and education institutions.
		▪ Provide incentives for nurse-employers that follow guidelines & decrease patient and nurse injuries.	By 2008	Incentives are in place.
		o State support competitions for Nursing Workplace Safety; engage State Accident Fund & MHA insurance entity.		

Issue 3.2: The efficiency and effectiveness of many nursing work processes are poor.

Issue	Recommended Action			Action Indicator
	Who	Does What	When	
3.2.2 (cont.) **[Also see Section 1.1.5 on retention & rehabilitation.]**	Nursing Organizations CNE, MHA, Patient Safety Commission, MDCH, MIOSHA, public & private workers' compensation agencies, OFIS, MEDC, universities, consultants	○ Educate CEOs, CFOs, COOs, Nurse Executives & Medical Directors on ergonomic guidelines and cost-benefit of implementation. ▪ Engage the medical equipment manufacturing community to innovate in the development of ergonomic medical equipment [Stryker; entrepreneurs]. ○ Explore shared-risk approaches to equipment development [MEDC]. ○ Promote benefit to Michigan economy through national & international healthcare market sales.	By 2007	Medical equipment manufacturing entities innovate lifting moving equipment for healthcare entities.

Issue 3.2: The efficiency and effectiveness of many nursing work processes are poor.

Issue	Recommended Action			Action Indicator
	Who	Does What	When	
3.2.3: The knowledge and expertise of professional nurses often are not fully utilized; delegation of tasks impacts the efficiency & effectiveness of nurses, since nursing as a profession has accumulated tasks that should be delegated to other staff categories. **See also Section 6, Scope of Nursing Practice, Issue 6.1.3 and Section 4, Nursing Education.**	CNE, Board, MCN, Nursing Organizations, MHA, ANA, Nursing schools, other partners, consultants	Utilize best practices & national models to educate nurses and inform nurse employers as to which tasks nurses should retain and which tasks nurses should delegate – and to whom – with flexibility for differing circumstances. ▪ Use best practices and national models to develop delegation algorithms and guidelines[11]. o Explore use of specialized assistants (volunteers or staff). o Explore use of robots/robotics (increase or decrease efficiency?) ▪ Use best practices and national models to develop delegation education (NIC-based model[12]). o Prepare nurses pre-licensure for competency in delegation. o Prepare nurses post-licensure for competency in delegation. (See Section 4, Nursing Education, Issue 4.2.3 re: nursing internships/residencies.) ▪ Use Collaborative Multidisciplinary Teams (see above) to educate health professionals on delegation. ▪ Encourage appropriate distribution & utilization of nurses' time, and matching of nurses' capacities to patient needs to improve efficiency & effectiveness.	By 2008	Delegation algorithms & guidelines are implemented by nurse employers. Nurses are educated pre- and post-licensure on appropriate delegation. Multidisciplinary Teams are educated on appropriate delegation.

Nursing Agenda – Section 3 – Work Design

Issue 3.2: The efficiency and effectiveness of many nursing work processes are poor.

Issue	Recommended Action			Action Indicator
	Who	Does What	When	
3.2.4: Electronic health information systems (EHIS) are often designed & implemented without adequate input from nurses responsible for patient care and quality assurance. As a result, EHIS often do not produce expected benefits in cost/efficiency/quality. Standardized formats & nursing terminology are not used in EHIS, which decreases the continuity, safety, and quality of patient care locally & nationally.	CNE, Nursing Organizations, MHA, MCN. Patient Safety Commission, ANA, federal agencies, IT businesses, consultants, HANDS Research Project	Enhance electronic health information systems locally & nationally to: improve the quality of nursing communication & decision-making in practice; promote continuity and safe patient care across nurses, providers, and care settings; and support interoperability of systems generating reliable nursing data used in evaluation and improvement of nursing care. ▪ Assure that nurse executives, and nurse clinicians of all levels are involved in design, selection, implementation, evaluation, and improvement of electronic health information systems (EHIS). ▪ Collaborate with & build on existing efforts to produce national nursing documentation terminology & data collection standards[13]. ▪ Promote learning & use of standardized nursing terminology by nursing students, faculty, administrators, and clinicians. ▪ Integrate standardized nursing terminology in EHIS nationally & locally to ensure consistency of nursing data and interoperability of EHIS. ▪ Require education & periodic re-education of all users of EHIS to ensure reliability and validity of data. ▪ Track reduction in healthcare error rates due to improved communication of information. ▪ Track reduction in documentation time of nurses and other healthcare professionals due to improved integration of EHIS.[14]	By 2010	Appropriate infrastructure and integrated electronic health information systems with standardized nursing terminology are in place and all users are appropriately trained.

[1] Safe Working Hours is a concept that takes into account the health and safety of both patients and nurses; it balances patient load and needs with the capacities of nursing staff, and is a flexible response to the needs of patients, nurses, and healthcare facilities. See references below.

[2] The October 12 to October 30, 2005 strike of nurses at Inghanm Regional Medical Center in Lansing, Michigan was settled with ratification of a three year contract addressing the issue of nurse staffing through additional hiring for three units in the hospital, plus a Nursing Council to have input to staffing. [Lansing State Journal, November 1, 2005.]

[3] Safe Working Hours must consider the detrimental effects of both mandatory and voluntary extended shifts and work weeks. The health and safety of both the patient and the nurse are negatively affected by the fatigue and stress associated with long work hours; for the nurse, this includes sleep deprivation, impaired decision-making, and other inescapable consequences of attempting to work too long and too hard. We regulate the shift length and time-between-shifts of pilots, bus drivers, and truck drivers, so that they will not endanger the health & safety of their passengers or others; surely nurses are no less significant to the health and safety of healthcare consumers. [Rogers, A.E., Hwang, W., Scott, L.D., Aiken, L.H., & Dinges, D.F. (2004). The working hours of hospital staff nurses and patient safety. *Health Affairs,* 23, 202-212.] [*JONA,* 2004] [Institute of Medicine. (2004). *Keeping patients safe: Transforming the work environment of nurses.* Committee on the Work Environment for Nurses and Patient Safety. Washington, D.C.: National Academy Press.] [Aiken, L.H., Havans, D.S., & Sloan, D.M. (2000). The magnet nursing services recognition program: A comparison of two groups of magnet hospitals. *American Journal of Nursing,* 100(3), 26-35.] [Malangoni, M., Como, J., Mancuso, C., & Yowler, C. Life after 80 hours: the impact of resident work hours mandates on trauma and emergency experience and work effort for senior residents and faculty. *Journal of Trauma-Injury Infection & Critical Care.* 58(4):758-61, 2005 Apr.]

[4] The Magnet hospital program recognizes workplaces that foster nursing excellence and support professional nursing practice. Such a workplace culture has been shown to improve patient outcomes, increase levels of patient/resident/client satisfaction, and significantly lower rates of nurse burnout. [American Nurses Association (2005). *ANA's Health Care Agenda 2005.*] [McClure, M.L. & Hinshaw, A.S. (2002). *Magnet hospitals revisited: Attraction and retention of professional nurses.* Washington, D.C.: American Nurses Publishing.] [Capuano, T., Bokovoy, J., Halkins, D., Hitchings, K. Work flow analysis: eliminating non-value-added work. *Journal of Nursing Administration* 34(5):246-56, 2004 May.]

[5] Hardin, S.R., Kaplow, R. (ed). (2005). *Synergy for clinical excellence: The American Association of Critical Care Nurses synergy model for patient care.* Boston: Jones & Bartlett.

[6] High Reliability Organizations are discussed and resource materials provided at: www.highreliability.org, http://healthcare.isixsigma.com, http://www.ncbi.nlm.nih.gov, http://www.ihi.org, and http://psnet.ahrq.gov.

[7] See the work of hospital architect Craig Johnson (funded by the Robert Wood Johnson Foundation) of Georgia Technology Institute for ways in which hospital design can improve the efficiency and efficacy of work for all health professionals, and particularly the work processes of nursing.

[8] A Continuous Quality Improvement Process (CQIP) involves educating all relevant workers/participants to identify problems that decrease quality, efficiency, & effectiveness, and propose solutions. Problems and potential solutions are brought to a CQIP committee (including administrators and staff), which prioritizes and implements solutions. Quality measures are collected and analyzed continuously to evaluate CQIP effectiveness. Once instituted, the CQIP approach becomes a permanent feature of the workplace, "continuous" rather than episodic [See Berwick, D.M., Godfrey, A.B., and Roessner, J. (1990). *Curing health care: New strategies for quality improvement.* San Francisco: Jossey-Bass.].

[9] See: Homola, J., Ergonomic program benefits, *Employee Safety & Disability Management Services News & Views,* June, 2001; American Nurses Association (2003). *Position Statement on Elimination of Manual Patient Handling to Prevent Work-Related Musculoskeletal Disorders.*

[10] The use of trained volunteers or alternative staff to lift/move patients is not a solution to the ergonomic stress problem. Forty years of back injury prevention education and body mechanics training have not provided effective management of this problem, since those who lift/move patients eventually sustain back

injury, adding further to the cost of healthcare. [D. Tyler, Project Communication, 2005.] See Swirczek, P., Uplifting possibilities: A multifaceted success story on the use of ceiling lifts in healthcare. *Employee Safety & Disability Management Services News & Views*, June 2001. This article call attention to the multiple advantages of appropriate moving/lifting equipment: improvements in patient and nurse health/safety; decreases in injuries, lost time, and associated costs; and improved recruitment and retention of nursing staff. Also see: Nielsen, K., Trinkoff A. (2003). Applying ergonomics to nurse computer workstations: review and recommendations. *Computers, Informatics, Nursing* 21(3):150-7, 2003 May-Jun.

[11] National Council of State Boards of Nursing: delegation algorithm. See: www.ncsbn.org.

[12] NIC is a nursing intervention classification terminology. It is often mentioned in company with NOC, a nursing outcomes classification terminology. Both have been developed over the past ten years by national nursing workgroups. See: http://nursingworld.org/nidsec/prtlist.htm.

[13] The Hands-on Automated Nursing Data Systems (HANDS) Care Planning Method integrates NANDA, NOC, and NIC terminologies, adheres to ANA NIDSEC data standards, and thereby ensures interoperability.

[14] Keenan, G., & Yakel, E. (in press). Promoting safe nursing care by bringing visibility to the disciplinary aspects of interdisciplinary care. *American Medical Informatics Association Fall 2005 Conference* (submitted paper). American Medical Informatics Association: Washington, D.C.

Keenan, G., Stocker, J., Geo-Thomas, A., Soporkar, N., Barkauskas, V., & J. Lee (2002). The HANDS project: Studying and refining the automated collection of a cross-setting clinical data set. *Computers, Informatics, Nursing*, 20(3):89-100.

Keenan, G. Principal Investigator (2004-2007). RO1 award from DHHS (NIH, AHRQ), *Health Information Technology (HIT): Support for Safe Nursing.*

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Nursing Agenda – Section 4 – Nursing Education

Issue 4.1: The shortage of appropriately prepared nursing faculty impedes nursing education capacity.

Issue	Recommended Action			Action Indicator
	Who	Does What	When	
4.1.1: The number of prepared faculty in the nursing education pipeline is insufficient[1].	CNE, MCN, Board, nursing schools/colleges, nursing organizations, nurse-employers, MHA, other partners.	Recruit faculty from clinical nursing and from both clinical and faculty retirees. Provide education and support resources for recruits. ▪ Develop teaching roles for retirees that do not include physically demanding clinical roles. o Educate retirees for both classroom and on-line teaching. o Develop more on-line courses. o Recruit from Retired Nurses Corps. [See Nursing Agenda, section 5.4.]	By 2007	Additional nursing faculty (recruited from clinical nurses and retired faculty) are in place.
		▪ Increase programs utilizing faculty practice split roles in which staff nurses are educated for clinical teaching[2] o Work with nurse-employers and nursing schools/colleges to provide a salary increment and other rewards for clinical preceptors/faculty. o Provide support (tuition, fees, appropriate stipends) to clinical preceptors/faculty who seek advanced nursing degrees.	By 2007	
		▪ Provide mentors during the entire process of education for advanced degrees and for faculty development.	By 2008	
		Make faculty salaries competitive with clinical acute care salaries. Explore models in other practice fields, such as medicine. ▪ Engage a broad stakeholder group (purchasers, payers, providers) in funding the recruitment & preparation of additional nursing faculty.	By 2008	

Nursing Agenda – Section 4 – Nursing Education

Issue 4.1: The shortage of appropriately prepared nursing faculty impedes nursing education capacity.

Issue	Recommended Action			Action Indicator
	Who	Does What	When	
4.1.1: The number of prepared faculty in the Nursing Education pipeline is insufficient [cont.].	CNE, MCN, Board, nursing schools/colleges, nurse-employers, nursing organizations, MHA, other partners.	Explore recruitment of faculty from related fields, including science & engineering, public health, social sciences, & social work. Provide education and support resources for those recruited. ▪ Develop teaching roles (not clinical or nursing theory) for faculty from related fields. o Prepare related-field faculty for both classroom & on-line teaching. o Develop appropriate on-line courses. Work with national accrediting agencies and Michigan State Board of Nursing to delimit roles for related field faculty. o Implement pilot project for nursing faculty recruited from related fields.	By 2008	Nursing faculty recruited from related fields are prepared and teaching as part of a pilot project.
	CNE, MCN, nursing schools/colleges, nurse-employers, MMA, MHA, other partners.	Maximize utilization of available faculty hours. Survey part-time faculty from ADN and BSN institutions; identify and engage those part-time faculty who would like to become full-time faculty. o Provide appropriate resources and supports for such faculty. o Work with healthcare stakeholders to identify funding for full-time salaries.	By 2007	Former part-time faculty members are engaged as full-time faculty in nursing education.
	CNE, MCN, Board, nursing schools/colleges, other partners.	Increase support for education of masters-prepared & doctoral-prepared faculty, including scholarships, loan forgiveness, livable stipends, & mentoring. Increase number of slots in fast-track Masters Degree programs.	By 2007	Additional supports for education of masters & doctoral-prepared faculty are in place. Fast-track Masters Degree programs increase slots available.

Nursing Agenda – Section 4 – Nursing Education

Issue 4.1: The shortage of appropriately prepared nursing faculty impedes nursing education capacity.

Issue	Recommended Action			Action Indicator
	Who	Does What	When	
4.1.2: The large number and variability of nursing education programs in Michigan affects faculty availability & distribution.	CNE, MCN, Board, nursing schools/colleges, MACN, MCNEA, other nursing organizations, nurse-employers, MLN, AACN, Legislature, other partners.	Assess the effects of concentrating programs (and therefore appropriately prepared faculty) in nationally accredited, large-enrollment schools.	By 2006	Deployment and utilization of nursing faculty are improved.
		▪ Develop process to facilitate transition of Michigan nursing schools/colleges to national accreditation.	By2008	
		o Work with educational institutions to facilitate transition to national accreditation system[3].	By2010	Timeline for transition is agreed & in place.
		o Seek resources and funding to incentivize national accreditation.	By2012	Nursing schools are nationally accredited.
		▪ Explore (at all Michigan nursing schools) a common ADN curriculum & (at public nursing schools only) a common ADN fee schedule.	By 2007	Recommendations are in place for common ADN nursing curriculum at Michigan nursing schools, plus consistent, expedited transition from ADN to BSN degree programs.
		o Support the work of the MACN and MCNEA task forces[4].		
		o Review examples/models of the common-curriculum process.		
		o Consider transferability of credits and tuition predictability/consistency.		
		o Consider increased quality of preparation of new nurses.		
		o Consider increased effectiveness of faculty as they change location.		
		▪ Encourage web-based programs/courses to provide nursing education to rural areas.	By 2007	Increased web-based courses are in place.
		▪ Determine "right" configuration of nursing education programs to utilize faculty most productively and preserve quality.	By 2008	Teaching productivity & quality are maximized.

Nursing Agenda – Section 4 – Nursing Education

Issue 4.2: There is an anticipated 30-year deficit of appropriately prepared nursing graduates.

Issue	Recommended Action			Action Indicator
	Who	Does What	When	
4.2.1: There is a short-range need for a quick infusion of appropriate prepared nursing graduates.	CNE, MCN, Board, nursing schools/colleges, nursing organizations, partners	Recruit individuals with Bachelor's degrees in related fields. Provide accelerated nursing education and support resources for those recruited. ▪ Expand existing second-degree programs[5]. ▪ Create additional second-degree programs, particularly at four-year universities ▪ Facilitate flexible timing for clinical placements needed by accelerated program students. ▪ Evaluate accelerated programs demonstrated under the 2005 *Accelerated Health Care Career Training Initiative* awards to nursing education institutions partnering with hospitals. Replicate successful programs. ▪ Track second-degree/accelerated programs, graduates, and their careers.	By 2006	Second-degree and accelerated program graduates are added to Michigan's nursing workforce.
	CNE, MCN, Board, nursing schools/colleges, MACN, MCNEA, nursing organizations, partners	Increase the number of BSN graduates by implementing the recommendations of the 2005 MACN/MCNEA task force on the ADN to BSN transition. ▪ Expedite the transition from ADN to BSN. ▪ Standardize the curricula at both degree levels ▪ Standardize the articulation (relationship) between the two degrees, so that ADN graduates can shift smoothly into a BSN program at any Michigan nursing school.	By 2007	A consistent relationship between ADN and BSN programs at Michigan public nursing schools is in place. The number of BSN graduates increases.

Nursing Agenda – Section 4 – Nursing Education

Issue 4.2: There is an anticipated 30-year deficit of appropriately prepared nursing graduates.

Issue	Recommended Action			Action Indicator
	Who	Does What	When	
	CNE, MCN, MHC, Board, nursing schools/colleges, nursing organizations, partners	Recruit minorities, males, persons with appropriate expertise/credentials, life experience, and skills. ▪ Promote nursing as a career for persons who have not previously considered nursing. ▪ Promote nursing as a second career for persons with appropriate preparation & capacities. ▪ Provide nursing opportunities for appropriate persons from occupational fields that are down-sizing. ▪ Provide baseline testing of persons recruited. ▪ Provide mentoring and support resources for persons recruited. ▪ Track non-traditional recruits, their programs, progress, & careers.	By 2007	Additional nursing graduates are added to Michigan's nursing workforce. Percentages of minorities and males in the nursing workforce are increased.
	CNE, MCN, MHC, Board, nursing schools/colleges, nursing organizations, partners	Recruit nurses with appropriate backgrounds, life experience and skills to be educated as Advanced Practice Nurses (APNs). ▪ Expand the number of slots available in current APN programs. ▪ Provide mentoring and support resources for persons recruited. ▪ Provide mentoring and support resources for persons preparing for faculty positions in APN educational programs.	By 2009	Additional Advanced Practice Nurses are added to Michigan's nursing workforce and provide a wide range of services from primary care to surgical anesthesia.

Nursing Agenda – Section 4 – Nursing Education

Issue 4.2: There is an anticipated 30-year deficit of appropriately prepared nursing graduates.

Issue	Recommended Action			Action Indicator
	Who	Does What	When	
4.2.2: There is a mid-range shortage of appropriately prepared entering nursing students.	CNE, MCN, MHC, Board, nursing schools/colleges, nursing organizations, partners	Improve the image of the nursing field with middle school and high school students of diverse cultures & ethnicities, their parents, and their guidance counselors. ▪ Work with media, school systems, career fairs, and all other identified channels. o Use resources from national associations and other best practice sources. o Emphasize web-based information, career testing, and other useful tools.	By 2007	Students, parents, teachers and guidance counselors have greater understanding of nursing as a profession with many opportunities.
[See Nursing Agenda Sections 1,2, & 3 for changes in nursing work environment and work design to improve the attractiveness of nursing as a profession.]		Recruit diverse middle school and high-school students of both sexes.[6] ▪ Identify male role models & ethnic role models to participate in recruitment efforts (videos, websites, site visits). ▪ Work with existing recruitment programs for related health fields; engage teachers. ▪ Work with existing recruitment programs for scientific and engineering fields. ▪ Develop extensive on-line recruitment materials for nursing programs. ▪ Emphasize essential preparatory courses for entry to nursing programs; engage teachers.[7] ▪ Create new recruitment programs (e.g., classroom visits by nursing students[8]). ▪ Provide opportunities for mentoring and shadowing experiences (e.g., direct-care nursing[9]). ▪ Improve compensation and reimbursement in nursing in general; reward education[10].	By 2007	Additional students of diverse cultures & ethnicities apply for admission to nursing programs and are supported in their goals.

Nursing Agenda – Section 4 – Nursing Education

Issue 4.2: There is an anticipated 30-year deficit of appropriately prepared nursing graduates.

Issue	Recommended Action			Action Indicator
	Who	Does What	When	
	CNE, MCN, Board, nursing schools/colleges, nursing organizations, partners	Improve availability of scholarships, livable stipends, & loan-forgiveness in nursing, both for entering students and mid-career students. ▪ Work with a broad stakeholder group of purchasers, payers, and providers to gain funding for nursing students & programs. ▪ Index stipends & loan-forgiveness to years of service (either before or after education received).	By 2007	Additional new & mid-career nursing students are supported in reaching their educational goals. Additional graduates join Michigan's nursing workforce.

Nursing Agenda – Section 4 – Nursing Education

Issue 4.2: There is an anticipated 30-year deficit of appropriately prepared nursing graduates.

Issue	Recommended Action			Action Indicator
	Who	Does What	When	
4.2.3: Nursing programs need the tools to improve rates of student retention, thereby using teaching resources more effectively.	CNE, MCN, Board, nursing schools/colleges, nursing organizations, partners	Improve rates of student retention in all nursing education programs. This is particularly important for ADN programs, the entering level for many nurses.		
		▪ Collect data about rates of student retention and the student reasons for leaving the program. Expected reasons include: o Student did not have sufficient funds to stay in school o Student had to spend too much time working to earn funds for school expenses. o Student was not adequately prepared in nursing program essentials – math, science, & reading comprehension. o Student was not prepared for demands & complexity of the nursing curriculum.	By 2006	Information is disseminated about student retention rates in Michigan nursing schools/colleges.
		▪ Facilitate faculty development program to enhance faculty awareness & support for both faculty & student diversity. o Begin statewide colloquium for faculty development on diversity awareness.	By 2006	Faculty awareness & support for diversity increases.
		▪ Increase student supports, including mentoring, tutoring, and all types of financial supports (see above).	By 2008	Financial & academic reasons to leave nursing programs are decreased.
		▪ Work with Retired Nurse Corps. to develop the role of Education Case Manager to assist students with all aspects of nursing education and the life management interface that may interfere with completion of the nursing program.[11]	By 2007	Education Case Manager pilot program is underway.

Nursing Agenda – Section 4 – Nursing Education

Issue 4.2: There is an anticipated 30-year deficit of appropriately prepared nursing graduates.

Issue	Recommended Action			Action Indicator
	Who	Does What	When	
4.2.4: There is a shortage of clinical placements and other necessary facilities to increase student completion of nursing programs and move them into practice.	CNE, MCN, Board, nursing schools/colleges, MACN, MCNEA, nursing organizations, Area Health Education Consortium (AHEC), other partners	Work with the Board, nursing schools/colleges, & the Michigan AHEC to increase availability of clinical placements that are needed to complete a degree or certification. Support the work of the MACN/MCNEA task force on the development of a new clinical model for nursing education.	By 2007	Additional clinical placement opportunities are made available to nursing students, 24/7, throughout the year.
		▪ Develop cooperative agreements with community partners (hospitals & clinics), smaller practice sites, public/community health, mental health[12], nurse-managed practices, & school-based health centers, etc.[13] [14]		
		▪ Develop regional consortia to facilitate clinical placements. Seek funding support for clinical faculty/mentors available in region.	By 2008	Regional consortia in place. Funding for clinical faculty available.
		▪ Explore maximization of available hours at clinical sites and with clinical faculty. o Consider availability of weekend or evening clinical placements. o Consider availability of summer clinical placement programs.	By 2008	Clinical site/faculty hours are maximized.
		▪ Consider use of web-based models to facilitate regional clinical placements[15]).	By 2007	Clinical placements are facilitated.
		▪ Expand use of regional technology centers in which expensive technology (simulations, laboratories, etc.) may be shared[16].	By 2008	Regional technology centers are in place.
		▪ Expand use of mentors & e-mentors during the entire process of education, licensure, and early career [recruit from Retired Nurse Corps.].	By 2008	Mentors are available during nursing student education & early career.
		▪ Expand use of on-line courses at all levels.	By 2007	

Nursing Agenda – Section 4 – Nursing Education

Issue 4.2: There is an anticipated 30-year deficit of appropriately prepared nursing graduates.

Issue	Recommended Action			Action Indicator
	Who	Does What	When	
4.2.5: There is a long-range need for alternative methods for educating nurses and faculty.	CNE, MCN, Board, nursing schools/colleges, nursing organizations, partners	Explore potential of multiple strategies identified as future mechanisms for nursing education: ▪ Expanded use of clinical simulations[17]. ▪ Expanded use of Regional Technology Centers in which expensive technology (simulations, laboratories, etc.) may be shared. ▪ Expanded use of mentors (and incentives for mentors) during the entire process of education, licensure, and early career. ▪ Expanded use of retired faculty mentors during the graduate education and early career of potential nursing faculty. ▪ Expanded use of on-line courses, on-line advanced-placement courses, and on-line graduate and certificate programs. ▪ Expanded use of evening, weekend, and summer programs (both didactic & clinical) to make education available to students with jobs. ▪ Expanded use of nursing internships & residencies to provide more intensive clinical experience for graduate nurses. ▪ Expanded use of fast-track graduate programs with appropriate supports for participants.	By 2008	Plans for implementation of future nursing education methodologies are in place.

Nursing Agenda – Section 4 – Nursing Education

Issue 4.3: Practicing Nurses do not have sufficient educational/career development resources.

Issue	Recommended Action			Action Indicator
	Who	Does What	When	
4.3.1: Practicing nurses need educational resources and support for career-development in mid-career and role-changes in late-career circumstances. **(See Sections 1& 2, Workforce & Work Environment for additional information on career development.)**	CNE, MCN, Board, nursing schools/colleges, nursing organizations, nurse employers, other partners	Work with nursing schools/colleges to increase availability of advanced degrees and certification programs. Programs to be made available include: ▪ LPN or Staff Nurse preparation for Long Term Care roles (with Clinical Nurse Specialist as member of patient care team). ▪ Care management/coordination roles. ▪ Public health & health promotion roles. ▪ Quality assurance & CQIP roles. ▪ Advanced Practice Nurses o Certified Registered Nurse Anesthetists o Certified Nurse Mid-wives o Nurse Practitioners ▪ Nurse-leader & nurse-mentor roles[18].	By 2007	Nurses have greater access to career ladder and career development educational programs.
		Increase scholarships, stipends, loan-forgiveness, & financial incentives for professional nurses in these programs. ▪ Work with a broad stakeholder group of purchasers, payers, & providers to develop financial support and rewards for these students and their programs[19] (for example, assure that completion of an advanced degree in nursing will lead to a salary increase rather than decrease, as is sometimes the case at present).	By 2008	Nurses have greater access to financial support & rewards as they increase their education.

Nursing Agenda – Section 4 – Nursing Education

Issue 4.3: Practicing Nurses do not have sufficient educational/career development resources.

Issue	Recommended Action			Action Indicator
	Who	Does What	When	
4.3.2: Nursing managers need educational resources and support to acquire needed leadership/management & finance education, and team-building skills.	CNE, MCN, nursing organizations, MHA, nursing schools/colleges, other partners	Provide support and incentives for nursing leadership/management programs, workplace mentoring, e-mentoring, and other on-line resources to assist upper & mid-level nursing managers in improving their skills. ▪ Work with nursing organizations, nursing schools/colleges, public health schools/colleges, business schools, and nurse employers to make the case for and provide: nursing leadership/management/finance education (advanced degrees and CEUs); worksite mentoring for managers; and nursing team-building education. See Retired Nurses Corps, Section 5.4. ▪ Provide incentives to individuals and institutions that take this path, including financial & career rewards for nurses who receive additional education & certifications.	By 2007	Nurses, nurse-employers, and educational institutions invest in nursing leadership/management/ finance education (advanced degrees and CEUs), worksite nurse-manager mentoring, and team-building education.

[1] More than 33% of full-time nursing faculty in Michigan are age 55 or older; more than 50% of adjunct faculty are age 45 or older. See Survey of Nursing Education Programs; 2002-2003 School Year: http://www.michigancenterfornursing.org.

[2] The 2005 Michigan *Accelerated Health Care Career Training Initiative* awarded grants to 21 consortia of healthcare facilities and nursing schools/colleges for development of programs to educate staff nurses for clinical teaching.

[3] The National Council of State Boards of Nursing has an excellent model for the transition to national accreditation.

[4] The Michigan Association of Colleges of Nursing (MACN) and the Michigan Council of Nursing Educators & Administrators (MCNEA) have identified three priority initiatives for Michigan nursing education. These include 1) partnering with nursing services, 2) developing a new clinical model for nursing education, and 3) increasing the number of BSN graduates, and expediting the ADN-to-BSN transition by standardizing the articulation between the two degrees. The task forces working on these three initiatives plan to report their initial recommendations and plans by September 15, 2005.

[5] Institutions with existing second-degree programs include Grand Valley State University, Michigan State University, University of Detroit-Mercy, & Wayne State University.

[6] See the Oregon Center for Nursing recruitment materials. [www.oregoncenterfornursing.org]

[7] Engage teachers through healthcare summer jobs for teachers; also educate and pay teachers to teach summer classes for high school students about healthcare careers.

[8] Improving the community image of nursing could also include promotion of nursing by nurses, articles about nursing in local media, nursing journals, & conference presentations; increase acknowledgment of nursing degree/certification attainment in local media, awards ceremonies, etc.

[9] Offer "Nurse for a Day" experiences to interested high school students with appropriate preparation and in appropriate clinical environments; (See Section 4.2.5) Regional Education Centers might be used as venues for such experiences. (For comparison, see State Police experience offered to high school students in controlled, simulated environments, Lansing State Journal, June 17, 2005.)

[10] Reward education not only in nursing, but also Master's degrees in related areas such as public health, business administration, and hospital administration.

[11] Mid-Michigan Community College has had success with a Nurse Mentor/Coach program in which students are paired with a retired nurse who mentors and coaches them in dealing with a broad range of educational and life challenges. This program has resulted in improved student retention. [Communication from Janet Parker, Mid-Michigan Community College Nursing Program, August 2005.

[12] Short staffing has meant that many potential clinical sites are reluctant to grant permission for student experiences. This is particularly relevant in psychiatric/mental health and community health nursing courses, where student enrollment cannot be increased without additional clinical sites. [Communication from Naomi Ervin, PhD, RN, Assistant Dean, Family, Community, and Mental Health Nursing, Wayne State University College of Nursing, September 2005.].

[13] Work with clinical sites/nurse employers & nursing schools/colleges to facilitate nursing student compliance with site access requirements (for infection control, i.e., students' verified immunizations, PPD tuberculin testing, and communicable disease history). Other requirements can be handled by the students' nursing schools/colleges. Such programs are in place and appropriately documented at many nursing schools/colleges. Acceptance of such documentation by clinical sites would facilitate clinical placements and should be included in clinical site agreements.

[14] Facilitate clinical placements by including in clinical site agreements specific provisions for responsibility/indemnification/liability in the case of disease exposure or injury to students or patients during the student practicum experience. Make such specific provisions consistent and standard in clinical site agreements statewide.

[15] The Capital Area Health Alliance and the West Michigan Nursing Advisory Council have successfully used web-based approaches to regional clinical placements for nursing students (www.afh.org/WMNAC.htm).

[16] The U. S. Dept. of Labor has granted $1.6 million to the Colorado Dept. of Labor and Employment to fund the first phase of the Work, Education, and Lifelong Learning Simulation (WELLS) Center. The WELLS Center will be one of the most sophisticated clinical education facilities in the country for nurses and nursing faculty. The Colorado Center for Nursing Excellence will oversee Center operations. The facility will include: patient simulation resources (computer-driven mannequins and the Visible Human DissectorT), with high-speed datacasting to make simulation experience available statewide. The Center has been developed by a collaborative that includes many Colorado universities/colleges, healthcare entities, and state agencies (www.coloradonursingcenter.org).

[17] Clinical simulations include broadband video, interactive CD-ROM/DVD, computerized mannequins, virtual reality, "Thin-Man" and other innovative electronic resources. Clinical simulations are in use for nursing education in several states, including Colorado (see above), Maryland, Oregon, & Washington.

[18] The AACN Clinical Nurse Leader nursing education program is currently being demonstrated in colleges and schools of nursing nationwide (www.AACN.org).

[19] Educate nurses and nurse employers to negotiate roles appropriate for nurses with advanced degrees with appropriate compensation.

Nursing Agenda – Section 5 – Economic Impact of Nursing

Issue 5.1: The economic benefit of nursing to the community, healthcare industry, public health, and overall economy is poorly understood.

Issue	Recommended Action			Action Indicator
	Who	Does What	When	
5.1.1: Understanding must be improved of the dollars brought into communities by healthcare and nursing[1].	CNE, Board, COMON, nursing organizations, MHA, nurse employers, Partnership for Michigan's Health	Derive (large employer) healthcare and nursing economic data from surveys, studies, and the 2004 and 2005 reports[2], *The Economic Impact of Health Care in Michigan;* analyze by region and disseminate. ▪ Include information on direct benefits (salaries & fringe benefits) and indirect benefits (induced jobs & spending). ▪ In collaboration with MHA and other nurse employers, develop information on nursing position vacancies by region and estimate losses to regional economy; project five-year trends.	By 2006	Report on the (large employer) Economic Impact of Healthcare and Nursing in Michigan is disseminated.
	CNE, Board, COMON, MCN, nursing organizations, nurse employers, Partnership for Michigan's Health, other partners	Collect and report information on the (small employer) economic impact of nurses working in: Home Healthcare agencies, Long Term Care facilities, Public Health, Schools (School-Based Health Centers), Occupational Health, and other community-based entities. ▪ Include information on direct benefits (salaries and fringe benefits) and indirect benefits (induced jobs and spending).	By 2007	Report on the (small employer) Economic Impact of Nursing in Michigan is disseminated.

Nursing Agenda – Section 5 – Economic Impact of Nursing

Issue 5.1: The economic benefit of nursing to the community, healthcare industry, public health, and overall economy is poorly understood.

Issue	Recommended Action			Action Indicator
	Who	Does What	When	
5.1.2: Understanding must be improved of the economic value of nursing in prevention services, surveillance, and early intervention activities. These activities decrease overall health care costs, decrease acute care costs, and lower health care and absenteeism costs to employers.	CNE, Board, COMON, MCN, nursing organizations, MHA, relevant partners, consultants	Collect and report information on the cost of preventive/early intervention care provided by nurses vs. the cost of emergency care or acute care provided in other venues. ▪ Example: Analyze cost of preventive or non-emergent care provided by: Occupational Health nurses in work environments, School Health nurses in SBHCs, Public Health nurses in the community, and APNs in nurse-managed clinics[3] vs. cost of care provided in a hospital ED for the same condition after it has become emergent.	By 2007	Report is disseminated on the economic value of nursing preventive and early intervention services.

Nursing Agenda – Section 5 – Economic Impact of Nursing

Issue 5.1: The economic benefit of nursing to the community, healthcare industry, public health, and overall economy is poorly understood.

Issue	Recommended Action			Action Indicator
	Who	Does What	When	
5.1.3: Understanding must be improved of the economic value of nursing in providing quality health care services (including primary care, care management and quality assurance). Quality health care services decrease overall health care costs, societal burden, and the economic burden of litigated health care errors[4].	CNE, Board, COMON, MCN, nursing organizations, MHA, relevant partners, consultants	▪ Collect and report information on comparison of primary care provided by APNs in nurse-managed centers[5] compared to cost of primary care provided by other health professionals[6] ▪ Collect and report information on the cost-effectiveness of care provided with nursing care/case/disease management compared to the cost-effectiveness of care provided with no nursing care/case/disease management. ▪ Collect and report information on the cost-effectiveness of care provided with nursing quality assurance compared to the cost-effectiveness of care provided with no nursing quality assurance. ▪ Collect and report information on the cost-effectiveness of other nurse-managed health services (offered in public health & community-based settings), such as family planning, primary care, immunizations, and health education). ▪ Collect and report information on the cost-effectiveness of services provided by Advanced Practice Nurses compared to the cost-effectiveness of similar services provided by other health professionals[7].	By 2006 By 2007 By 2008 By 2008 By 2008	Report is disseminated on the economic value of nursing in providing high quality preventive & primary care[8], care management, quality assurance, community-based services, and specialty services such as obstetrics and anesthesia..

Nursing Agenda – Section 5 – Economic Impact of Nursing

Issue 5.1: The economic benefit of nursing to the community, healthcare industry, public health, and overall economy is poorly understood.

Issue	Recommended Action			Action Indicator
	Who	Does What	When	
5.1.4: Understanding must be improved of the economic value of nursing in providing high-quality patient direct-care services. **[See Section 1, Workforce, Issue 1.3.2.]**	CNE, Board, MCN, MHA, nurse employers, MDCH, MMA, healthcare purchasers & payers, nursing organizations, nursing schools/colleges, other partners	Demonstrate the value of nursing services in direct care settings by invoicing specifically for nursing services ▪ Establish a billing framework in which hours of nursing services (by type) are listed on patient bills and payer invoices. o Convert nursing services from a "bundled" cost center to a "billable-hours for services rendered" revenue center[9]. ▪ Work with State Medicaid (MSA), BCBSM, MAHP, and other purchasers and payers to develop the policy and systems changes required. ▪ Work with nurse employers to implement the systems changes required.	By 2009	Nursing services become a revenue center and nursing hours are "billable hours". The economic value of direct-care nursing is better appreciated.

Nursing Agenda – Section 5 – Economic Impact of Nursing

Issue 5.1: The economic benefit of nursing to the community, healthcare industry, public health, and overall economy is poorly understood.

Issue	Recommended Action			Action Indicator
	Who	Does What	When	
5.1.5: The economic benefit provided by retired nurses currently is under-appreciated and undervalued.	CNE, Board, MCN, nursing organizations, MHA, nurse employers, OFIS, nursing schools/colleges, Executive, Legislature	Demonstrate the value of nursing in multiple health care environments by instituting the Retired Nurse Corp. to provide oversight and mentoring to student nurses, graduate-student nurses, direct-care nurses, APNs, and community-based nurses[10]. ▪ Recruit retired nurses to participate in the Retired Nurse Corp. ▪ Members of the RNC will volunteer to serve as mentors for nursing undergraduate and graduate students. o Collect data on success rates of nursing students with/without RNC mentors. ▪ Members of the RNC will volunteer to serve as mentors in LTC facilities to provide support and input for RNs, LPNs and NA's. o Collect data on nursing retention & quality of care changes in LTC facilities served by members of the RNC. ▪ Provide incentives to retired nurses participating in the RNC indexed to the number of verified hours of service per year. ▪ Expand range of healthcare venues in which the RNC provide oversight and mentoring services to include hospitals, home health agencies, school-based health centers, public health and other venues as appropriate	By 2007 By 2008 By 2008	Retired Nurse Corp. is in place. Recruitment and placement of retired nurses as mentors is underway. Incentives are provided to members of the RNC. RNC activities expand to a wide range of healthcare venues.

Issue 5.1: The economic benefit of nursing to the community, healthcare industry, public health, and overall economy is poorly understood.

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[1] Capitol Area Michigan Works, MDLEG, IRMC, SHS, and other healthcare employers (2005). *Healthcare: The Jobs Machine.* (The economic effect of healthcare employment in Ingham, Eaton, & Clinton counties.)

[2] Partnership for Michigan's Health. (2004) (2005) *The Economic Impact of Health Care in Michigan.* Also see: www.economicimpact.org

[3] Vonderheid, S., Pohl, J., Barkauskas, V., Gift, D., Hughes-Cromwick, P., Financial Performance of Academic Nurse-Managed Primary Care Centers, *Nursing Economics,* 21(4), 2003.

[4] Stanton, M., Hospital Nurse Staffing and Quality of Care. *Research in Action, Issue 14.* (http://www.ahrq.gov/research/nursestaffing/nursestaff.htm). Also see: Blendon, R., et al. Views of Practicing Physicians and the Public on Medical Errors, *New England Journal of Medicine* 347(24):1933-1940, 2002 Dec 12.

[5] Vonderheid, S., Pohl, J., Schafer, P., Forrest, K., Poole, M., Barkauskas, V., Mackey, T. Using FTE and RVU Performance Measures to Assess the Financial Viability of Academic Nurse-Managed Primary Care Centers, *Nursing Economics,* 22(3), 124-134, 2004.

[6] US News & World Report, March 2005. *Nurses have the data to show the value of their care.*

[7] Cost studies have been made of Advanced Practice Nursing services in the areas of primary care provision, and obstetrics/gynecology over the past few years. It is proposed that additional studies focus on the cost effectiveness (cost, care, quality, outcomes) of APN nursing services in the areas of anesthesia, obstetrics, and primary care.

[8] Barkauskas, V., Pohl, J., Benkert, R., Wells, M. Measuring Quality in Nurse-Managed Centers Using HEDIS Measures, *Journal for Healthcare Quality,* 27(1), 2005.

[9] Billable hours for services rendered could include: fee for hours of service rendered for the physical assessment of a patient; for preparation and administration of an injection, or IV, or medication; for documentation of the medication, dosage, and time administered; for time used to assess a patient's pain level; and for time involved in the follow-up assessment of the reduction of pain level, with length of times for assessments throughout a 24-hour period. Such a billing arrangement is consistent with the healthcare facility billing approach for physical therapy, occupational therapy, and dentistry. (Communication from Ada Sue Hinshaw, Dean, University of Michigan School of Nursing, August 2005.)

[10] Norman, L, Donelan, K, Buerhaus, P, et al. The Older Nurse in the Workplace: Does Age Matter? *Nursing Economics,* 2005;23(6):282-289. Jannetti Publications, Inc.

Nursing Agenda – Section 6 – Scope of Nursing Practice

Issue 6.1: The integrity and standards of professional nursing practice in Michigan must be maintained.

Issue	Recommended Action			Action Indicator
	Who	Does What	When	
6.1.1: The integrity of professional nursing practice must be maintained to ensure patient safety and high-quality care. **[See Nursing Agenda Section 4, Nursing Education]**	CNE, Board, COMON, MCN, nursing organizations, nursing schools/colleges, Legislature, Executive	Ensure that only licensed nurses define Nursing & Nursing Practice in Michigan. ▪ Establish an official "Nursing Credentials & Terminology Commission" (NCTC) under the Office of the Chief Nurse Executive, the Michigan Board of Nursing, and the MCN; provide representation on the Commission for all professional nursing education and practice organizations. ▪ Establish the NCTC & its successor entity, as the entity chartered to define Nursing Credentials & Terminology in Michigan. ▪ Within the framework of the Public Health Code (as amended) and national standards, work with the NCTC to establish terminology for categories of nursing and the credentials that attach to each category [RN, LPN, APN, etc.]. o Educate nurses, the public and policy-makers on nursing terminology & credentials [RN, LPN, APN, etc.]. o Educate nurses, the public & policy-makers on nursing advanced degrees & continuing education (CE). A degree is not the end of education; nurses are always learning.[1]	By 2006 By 2006 By 2008 By 2009	Commission on Nursing Credentials and Terminology is in place. Commission's charter as the entity empowered to define Nursing in Michigan is in place. Categories/credentials for Nursing are in place. Nurses, public & policy-makers receive education on nursing terminology & credentials, and on nursing education & CE.

Nursing Agenda – Section 6 – Scope of Nursing Practice

Issue 6.1: The integrity and standards of professional nursing practice in Michigan must be maintained.

Issue	Recommended Action			Action Indicator
	Who	Does What	When	
	CNE, Board, COMON, MCN, nursing organizations, nursing schools/colleges, Legislature, Executive	▪ Frame and propose amendments to the Public Health Code as necessary to support nursing terminology and credentialing, with attention to the requirements of patient safety, high-quality patient care, and cost-effectiveness. A Nursing Practice Act may be needed[2]. o Work with Legislature and Executive to ensure passage and signing of PHC amendments.	By 2009 By 2009 By 2009	Public Health Code Amendments are reviewed and changed as necessary. Nursing Practice Act is under consideration. Public Health Code Amendments are under consideration.
6.1.1: (cont.)	CNE, Board, COMON, MCN, nursing organizations, nursing schools/colleges Legislature, Executive	▪ Work with the Deans of Nursing Schools & Colleges to develop timelines for bringing nursing education and degrees into compliance with the terminology and credentialing standards developed by the Commission.	By 2010	Nursing schools & colleges agree on timelines to bring nursing education and degree categories into compliance with Commission standards.
		▪ Support and continue the work of the Board in assessing/reviewing the national Nursing Licensure Compact, which has implications for licensure, education, and discipline. Ensure periodic review of the status of the Nursing Licensure Compact and the associated benefits/detriments for Michigan	By 2006	Board has completed assessment & review of the Compact. A course of action is proposed. Periodic status review is scheduled.

Nursing Agenda – Section 6 – Scope of Nursing Practice

Issue 6.1: The integrity and standards of professional nursing practice in Michigan must be maintained.

Issue	Recommended Action			Action Indicator
	Who	Does What	When	
6.1.2: The quality of care provided by professional nurses in Michigan must be maintained.	CNE, Board, COMON, MCN, nursing organizations, nursing schools/colleges, consultants, Legislature, Executive	Ensure that educational and professional standards are maintained.		
		▪ Establish a Nursing Education and Professional Standards Commission (NEPSC) under the CNE, Nursing Board, and MCN; ensure representation for nursing educators and professional nursing practice organizations on the Commission.	By 2006	NEPSC is in place.
		▪ Establish the NEPSC, and its successor entity, as the entity chartered to define nursing education and practice standards, using nationally recognized Professional Standards of Practice.	By 2006	Commission's charter as the entity empowered to define Nursing Education & Practice in Michigan is in place.
		▪ Review and strengthen nursing education programs & practice standards, with emphasis on high-quality patient-centered care, evidence-based care, preventive care & national models.	By 2008	Strengthened nursing education & practice standards are in place.
		o Frame/propose amendments to the Public Health Code as necessary to support revised nursing education & practice standards; a Nursing Practice Act may be needed.[3]		Nursing Practice Act is under consideration.
		o Recommend that all Michigan nursing schools & colleges shift to national accreditation of nursing programs.		
		o Work with Legislature and Executive to ensure passage and signing of PHC amendments.	By 2009	PHC amendments are under consideration.
		o Set national accreditation timeline for nursing schools & colleges, and assist with strategies to meet timeline by 2012	By 2009	Timeline for shift to a) national accreditation & b) revised practice standards is in place.
		o Set timeline for implementation of revised nursing practice standards by 2010.	By 2009	

Issue 6.1: The integrity and standards of professional nursing practice in Michigan must be maintained.

Issue	Recommended Action			Action Indicator
	Who	Does What	When	
6.1.1 & 6.1.2: (cont.)	CNE, Board & Commissions, MCN, & consultants	▪ Gather and analyze data on nursing terminology, credentialing, education and practice, and compare to national information. o Educate and report to nurses, the public and policy-makers on a quarterly basis. Utilize the Board's Annual Program Review Report as a channel, plus others as appropriate.	By 2009 By 2010	Nurses, public & policy-makers regularly receive educational reports on Nursing Terminology, Credentialing, Education, & Practice. High quality nursing care is consistently provided & outcomes reported.

Nursing Agenda – Section 6 – Scope of Nursing Practice

Issue 6.1: The integrity and standards of professional nursing practice in Michigan must be maintained.

Issue	Recommended Action			Action Indicator
	Who	Does What	When	
6.1.3: Nursing Practice currently includes many non-nursing tasks & fails to include many appropriate nursing tasks.	CNE, Board, MCN, NEPS Commission, MHA, nurse employers, nursing organizations, nursing schools/colleges, consultants	Promote appropriate expansion and delegation of nursing practice[4]. ▪ NEPS Commission annually to identify appropriate areas of expansion for Nursing Practice, particularly for Advanced Practice Nurses. o Work with MHA, Public Health and other nurse-employers to identify such areas, and the training, credentials & standards that accompany such expansion. o Educate employers, nurses, other health professionals, and the public on changes in Scope of Practice. ▪ NEPS Commission annually to identify appropriate areas of delegation for Nurses at each level of defined Terminology. o Work with MHA, Public Health, and other nurse-employers to identify appropriate delegation (to other staff) of tasks, and the training, credentials & standards required for those receiving & performing such tasks. o Educate employers, nurses, other health professionals, and the public on changes in Scope of Practice. o Ensure provision of appropriate educational content on delegation for student nurses and practicing nurses.	By 2007 By 2007 By 2008 By 2008 By 2008	Nursing Practice expansion areas are identified and promulgated annually. Education on changes in Nursing Scope of Practice is available. Nursing Practice delegation areas are identified and promulgated annually. Education on changes in Nursing Scope of Practice is available. Education on delegation is available.

Issue 6.2: Funding & regulatory systems must be improved to maintain the integrity & standards of professional nursing practice in Michigan.

Issue	Recommended Action			Action Indicator
	Who	Does What	When	
6.2.1: Maintaining the integrity & standards of professional nursing practice in Michigan requires increased financial resources and improved regulatory services. **At present, data acquisition, planning, & action on nursing workforce issues, (scope of practice, work environment, regulation, and discipline) are slow and difficult to access due to funding deficiencies, institutional fragmentation, and confused lines of authority.**	CNE, Board, MDCH, COMON, MCN, MHA, nursing organizations, nursing schools/colleges, consultants, Legislature, Executive	Provide value-added services for nurses & patients in Michigan by increasing the current nurse licensure assessment to leverage opportunities for additional other funds. Examples of value-added services include: ▪ Support the rapid preparation of additional nursing faculty to increase the capacity of existing nursing education programs in Michigan. [See Section 4, Nursing Education.] ▪ Support the development and implementation of nursing work design innovations and improvements in the nursing work environment. ▪ Support the development and implementation of the Retired Nurses Corp. ▪ Support the development and maintenance of a CNE website to both receive and disseminate information relevant to nursing policy. ▪ Ensure that regulation efficiently supports nursing practice and nursing education (i.e., improve responsiveness, awareness, and staffing). ▪ Support development & implementation of the NCT & NEPS commissions (see Sections 6.1.1 & 6.1.2) to strengthen and improve nursing. ▪ Support development & implementation of a *Nursing/Public Health Code Task Force* to review sections of the PHC directly or indirectly impacting nursing, and recommend changes (see below).	By 2007	Value-added services for nurses are funded through licensure & other funds.

Issue 6.2: Funding & regulatory systems must be improved to maintain the integrity & standards of professional nursing practice in Michigan.

Issue	Recommended Action			Action Indicator
	Who	Does What	When	
6.2.1: (cont.)	CNE, Board, MDCH, COMON, MCN, MHA, nursing organizations, nursing schools/colleges, consultants, Legislature, Executive	Review purpose, structure, & functions of the MDCH Bureau of Health Professions & the Board of Nursing with respect to the needs of nurses & nursing. ▪ Strengthen & empower nursing representation within the Bureau, and/or shift nursing regulatory tasks to the office of the CNE. ▪ Concentrate nursing regulatory & disciplinary tasks in the MDCH nursing profession focus, whether that is within the Bureau or in the CNE office.	By 2007	Nursing regulatory & disciplinary tasks are concentrated in a single nursing profession focus within MDCH. Information & action availability increases.
		▪ Ensure appropriate staffing, policies, procedures, and partners for the nursing profession focus of the MDCH [CNE or Bureau of Health Professions] to deal with Scope of Practice questions from nurses, the public, nursing schools/colleges, and employers: o Provide information & direction to Nursing Education programs. o Provide information & direction to nurses, employers, public health & public.	By 2007	Appropriate staffing, policies, procedures and partners are in place at MDCH; mechanisms are in place for periodic review and improvement.
		▪ Identify the appropriate role of the State Board of Nursing with respect to approval of nursing education programs. ▪ Review State Board of Nursing policies & procedures with respect to licensure.[5]	By 2007	Report is issued on education role of State Board of Nursing
		▪ Convene a special *Nursing/Public Health Code Task Force* to a) recommend changes in the PHC to bring it up to date on nursing practice, best practices, & national models; b) develop the framework for a Nursing Practice Act, including Scope of Practice.	By 2007	Public Health Code nursing changes are recommended. Nursing Practice Act under consideration.

[1] The NCTC should encourage membership and participation in professional nursing organizations by identifying those organizations carrying CEU credits towards Michigan licensure requirements.

[2] See National Council of State Boards of Nursing model Nursing Practice Act. See Article II, Scope of Nursing Practice and Chapter 2, Standards of Nursing Practice. (http://www.ncsbn.org/regulation/nursingpractice_nursing_practice_model_act_and_rules.asp).

[3] Wellness care in clinical settings should include patient health assessments and patient health education provided by licensed, credentialed, professional nurses.

[4] See: Klein, T.A., Scope of practice and the Nurse Practitioner: Regulation, competency, expansion, and evolution. *Topics in Advanced Practice Nursing e-Journal* 5(2):, 2005. Medscape.

[5] The legitimacy of dual RN & LPN licensure should be reviewed.

Glossary for Recommended Actions Tables

AACN	American Association of Colleges of Nursing
ACCN	Association of Critical Care Nurses
AHEC	Area Health Education Consortium
ANA	American Nurses Association
APN	Advanced Practice Nurse
Board	Michigan State Board of Nursing
CNE	Michigan Chief Nurse Executive
COMON	Coalition of Michigan Organizations of Nursing
HFHS	Henry Ford Health System, Detroit, Michigan
IRMC	Ingham Regional Medical Center, Lansing Michigan
Legislature	Michigan Legislature
LPN	Licensed Practical Nurse
MACN	Michigan Association of Colleges of Nursing
MCN	Michigan Center for Nursing
MCNEA	Michigan Council of Nursing Educators and Administrators
MDCH	Michigan Department of Community Health
MDLEG	Michigan Department of Labor and Economic Growth
MEDC	Michigan Economic Development Corporation
MHA	Michigan Health and Hospital Association
MLN	Michigan League for Nursing
MMA	Michigan Manufacturers Association
MNA	Michigan Nurses Association
MONE	Michigan Organization of Nurse Executives
MSA	Medical Services Administration – Michigan Medicaid -- MDCH
NA	Nurse's Aide
NCSBN	National Council of State Boards of Nursing
OFIS	Office of Financial and Insurance Services -- MDLEG
PHC	Michigan Public Health Code
RN	Registered Nurse
SHS	Sparrow Health System, Lansing, Michigan

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Appendix C

Additional Information Resources

Suggested Websites for Additional Information on Nursing and Health Policy

www.aacn.org (website of the American Association of Colleges of Nursing)

www.aha.org (website of the American Hospital Association)

www.nursingworld.org (website of the American Nurses Association)

www.nursingworld.org/ancc/magnet/facilities.html (magnet hospital information from the American Nurses Credentialing Center)

www.aone.org (website of the American Organization of Nurse Executives)

www.kaiserfamilyfoundation.org (website of the Henry J. Kaiser Family Foundation)

www.discovernursing.com (website of Johnson & Johnson Health Care Systems, Inc.)

www.michigan.gov/mdch/ocne (website of the Michigan Department of Community Health, Office of the Michigan Chief Nurse Executive)

www.michigancenterfornursing.org (website of the Michigan Center for Nursing)

www.nln.org (website of the National League for Nursing)

www.rwjf.org (website of the Robert Wood Johnson Foundation)

http://bhpr.hrsa.gov/healthworkforce/ (nursing workforce information from the US Dept. of Health & Human Services, Health Resources and Services Administration, Bureau of Health Professions, National Center for Health Workforce Analysis)

http://stats.bls.gov (nursing workforce information from the US Dept. of Labor, Bureau of Labor Statistics)

http://www.dol.gov/wb/factsheets/Qf-nursing.htm (nursing statistics from the US Dept. of Labor, Women's Bureau)

www.wmnac.org (website of the Western Michigan Nursing Advisory Council)

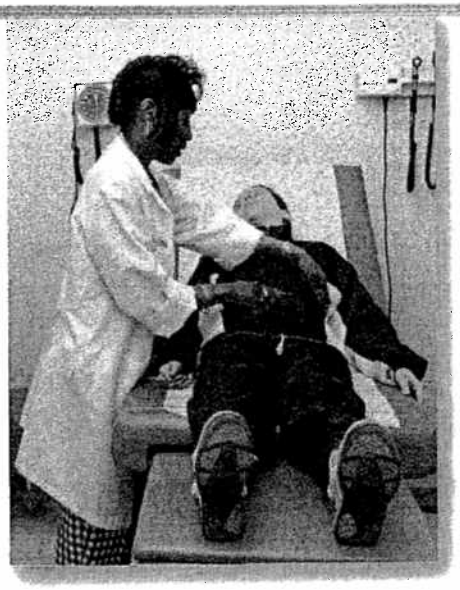
The complete Nursing Agenda for Michigan is available online at: www.michigan.gov/mdch/ocne

Actions to Avert a Crisis

Ten Things You Need to Know About the Nursing Shortage

1. Michigan and the nation are facing a 30-year shortage of nurses (Registered Nurses, Licensed Practical Nurses, and Advanced Practice Nurses).
2. Nurses are Michigan's largest licensed healthcare professional group – 145,996 licensed in 2005 [119,152 RNs; 26,844 LPNs].
3. Michigan's shortage of RNs (demand exceeds supply) will be 7,000 nurses in 2010, 18,000 nurses by 2015, and an estimated 30,000 nurses in 2020. Our healthcare system cannot function without adequate numbers of well-prepared nurses.
4. **Demand** for nurses will continue to increase as our population ages. Over the next thirty years, the Baby-Boom generation (76 million people now age 41-60) will require extraordinary amounts of healthcare.
5. **Demand:** The U.S. Census estimates that in 2030 Michigan's population will include 2,420,447 people age 65 and older, with 287,089 of those people age 85 and older.
6. **Demand:** The majority of healthcare is provided by professional nurses or those supervised by professional nurses in hospitals, psychiatric mental health & substance abuse centers, public health clinics, physician offices, industrial health clinics, nursing homes, home health, and other healthcare settings.
7. **Demand:** The availability of professional nurses is a major factor in all the strategic plans for national, state, and local responses to bio-terrorism, epidemics and pandemics, and natural disasters.
8. **Supply:** Over 92% of Registered Nurses are women. In the past 35 years, the range of occupations open to women has greatly expanded and fewer young women have entered nursing.
9. **Supply:** Nursing education's production of additional nurses is already declining, due largely to shortages of a) qualified nursing faculty (average age 51.1) and b) clinical education sites.
10. **Supply:** The nursing workforce is aging, with an average age of 46.1 years for Registered Nurses in Michigan. Many nurses have left the profession for other opportunities.

Nurses have taken the lead in addressing the nursing workforce crisis. The Coalition of Michigan Organizations of Nursing (COMON) has identified issues and recommended actions. **The Nursing Agenda for Michigan** has been shaped by the ideas and experience of hundreds of nursing leaders and practicing nurses from a wide range of nursing specialties; it was developed in collaboration with the Office of Michigan's Chief Nurse Executive (Michigan Department of Community Health) and other concerned organizations. For ten things we can do about the nursing shortage, turn this page over.



The Nursing Agenda for Michigan — *Summary*

Ten Things We Can Do About the Nursing Shortage

Recommended Short Range Actions

Healthcare System and Work Changes

1. Promote safe working hours to improve both patient & nurse safety and retention of the existing nursing workforce.
2. Improve the organization and design of nursing tasks to make them more efficient and effective, and to improve nurse retention.
3. Improve the ergonomics of nursing tasks to improve the health & safety of patients and nurses.
4. Set up collaborative multidisciplinary teams to manage & deliver patient care and increase shared decision-making.
5. Create a more respectful and supportive nursing workplace to improve retention of the existing nursing workforce.

Nursing Education Changes

6. Increase availability of nursing faculty by a) adding slots in fast-track master's programs, b) recruiting additional faculty from clinical nursing and from both clinical and faculty retirees, and c) tapping into underutilized faculty capacity.
7. Add new nurses to the workforce by increasing the number of student slots available in second-degree accelerated nursing programs.
8. Maximize the use and availability of web-based instruction and other technologies in nursing education.

Regulatory & Licensure Changes:

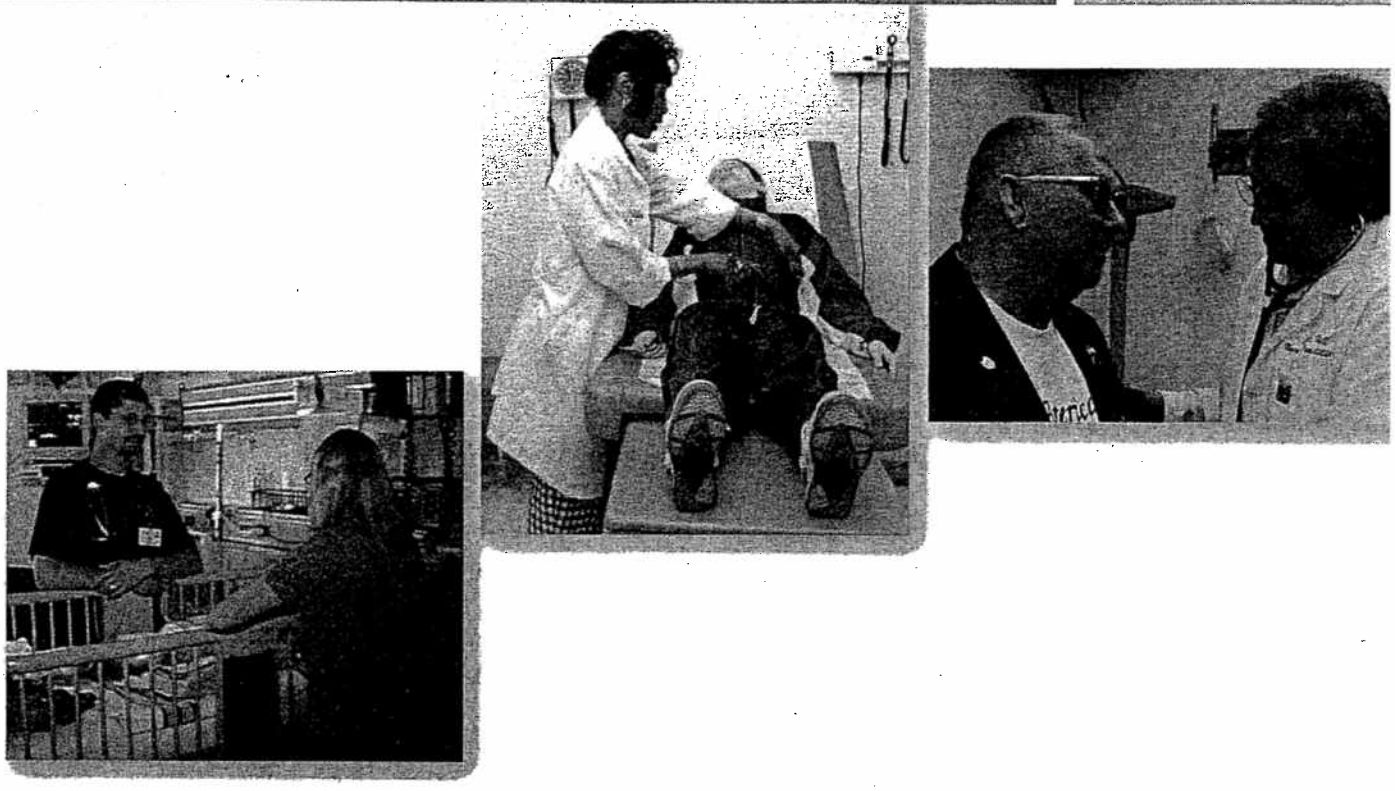
9. Use an increased nursing license fee to provide assistance to the nursing workforce. For example, increase the outreach and responsiveness of the regulatory apparatus, so that licensure is not delayed.
10. Increase mentoring, support, and oversight for all stages of nursing careers, from student to retirement, by engaging and supporting qualified retired nurses in a multitude of roles.

Old solutions to nursing shortages will not work in this new and complex environment of demographic extremes, public health preparedness, health systems issues, and economic issues. These times call for bold, rapid actions and responses, such as the 2005 **Accelerated Health Care Training Initiatives.** The **Nursing Agenda for Michigan** includes the short-range, mid-range, & long-range action steps we must take to ensure an adequate supply of well-prepared, professional nurses — the nurses who will care for Michigan residents today and in the future. For ten things you need to know about the nursing shortage, turn this page over.

See the complete **Nursing Agenda** online at:
www.michigan.gov/mdch/ocne

Contact the **Office of the Michigan Chief Nurse Executive**
Michigan Department of Community Health
517-241-9841

January 2006



The **Nursing Agenda** for Michigan: 2005–2010

Actions to Avert a Crisis

COMON Coalition of Michigan Organizations of Nursing

2006

for Michigan

Actions to Avert a Crisis

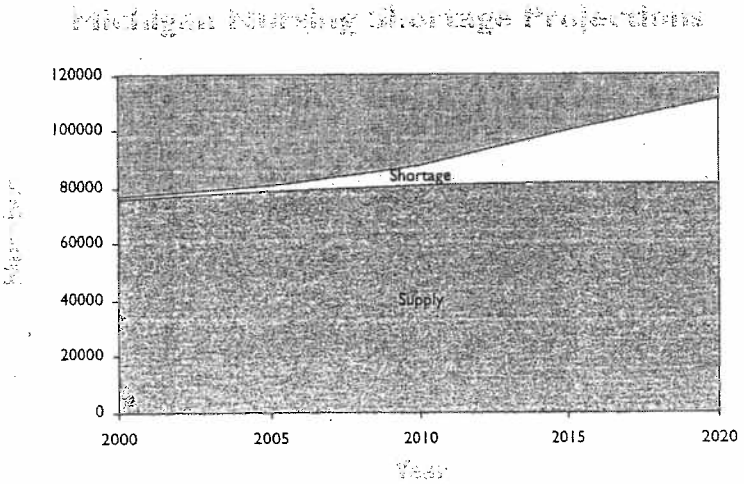
EXECUTIVE SUMMARY

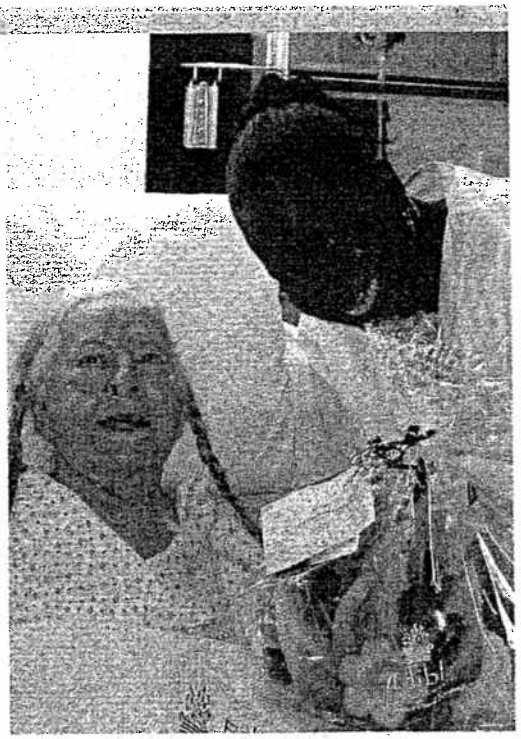
Why Do We Need a Nursing Agenda? Michigan and the nation are facing a thirty-year shortage of nurses (Registered Nurses, Licensed Practical Nurses, and Advanced Practice Nurses). Nurses are Michigan's largest licensed healthcare professional group – 145,996 licensed in 2005 [119,152 RNs; 26,844 LPNs]. Michigan's demand for RNs is expected to exceed supply by 7000 nurses in 2010, with a shortage of 18,000 nurses by 2015[1]. Extrapolating the supply/demand figures provides a nursing shortage estimate of 30,000 in 2020.

In hospitals, rehabilitation centers, psychiatric mental health & substance abuse centers, public health centers, clinics, urgent care centers, physician offices, industrial health clinics, nursing homes, home health, and other healthcare settings, the majority of care is provided by professional nurses, staff supervised by professional nurses, or family caregivers in the home, who are supported by nurses. The demand for nurses is increasing and will continue to increase across all the settings in which nurses practice. However, over the next 15 years, the Michigan nursing workforce is projected to remain at about the current level. Nursing education production of additional nurses is already declining, due largely to shortages of a) qualified nursing faculty and b) clinical education sites

The Coalition of Michigan Organizations of Nursing (COMON) includes 28 nursing organizations representing thousands of Michigan nurses (see list on back page). Over the past two years, COMON has engaged Michigan's nursing leaders and practicing nurses in an inclusive effort to identify issues and recommend practical actions to avert the nursing workforce crisis.

How Did We Reach This Point? The demand for nurses is greater than the supply.





Major demand factors include:

- The aging of our population. The Baby-Boom generation (76 million people) now ranges from age 41 to 60. Over the next thirty years, this generation will require extraordinary amounts of healthcare. The U.S. Census estimates that in 2030 Michigan's population will include 2,420,447 people age 65 and older, with 287,089 of those people age 85 and older.
- An increase in chronic disease among people of all ages, thereby increasing care needs.
- Changes in the healthcare system. Many conditions that led to hospitalization in the past now receive outpatient treatment. People admitted to hospitals today are much sicker than were people in hospitals ten years ago; their care is hi-tech, complex and demanding.
- National concerns about bio-terrorism, epidemics of infectious diseases, natural disasters, and the ability of our health care system to meet these challenges. Nurses are a major factor in all the strategic plans for national, state, and local responses to such threats.

[1] Michigan Department of Labor & Economic Growth (2004). The Health Care Sector and Michigan's Economy. Also Health Resources and Services Administration, Bureau of Health Professions (2002). Projected Supply, Demand and Shortages of Registered Nurses: 2000-2020. Washington, DC: U.S. Department of health & Human Services.

"Employment of Registered Nurses is expected to grow faster than the average for all occupations through 2012...more new jobs are expected to be created for RNs than for any other occupation. Thousands of job openings also will result from the need to replace experienced nurses who leave the occupation."

-U.S. Bureau of Labor Statistics

The supply of nurses is dependent upon:

- The number of new nursing graduates entering the field. Over 92% of Registered Nurses are women. In the past 35 years, the range of occupations open to women has greatly expanded. Fewer young women have entered nursing than in the past.
- The capacity of nursing education to produce adequate numbers of new nurses. Those who educate new nurses, the nursing faculty, have an average age of 51.1 years. Even if there is an increase in the number of young people seeking to become nurses, we cannot increase education of new nurses without additional nursing faculty and sites for clinical education.
- The number of existing nurses remaining in the field. Nationally, the nursing workforce is aging, with an average age of 46.1 years for Registered Nurses in Michigan. Many existing nurses have left the profession for opportunities in other fields.

The result has been a declining supply of nurses in Michigan and the nation. Nurses from other countries have been recruited, but that is not a long-term solution. Without adequate numbers of professional nurses, our healthcare system cannot function.

What Do We Need To Do? Nurses have taken the lead in addressing the nursing workforce crisis. The Coalition of Michigan Organizations of Nursing (COMON) has identified issues and recommended actions in six major areas: Workforce, Work Environment, Work Design, Nursing Education, Economic Impact and Scope of Nursing Practice (see full report for Action Plans). This **Nursing Agenda for Michigan** has been shaped by the ideas and experience of hundreds of nursing leaders and practicing nurses from a wide range of nursing specialties, as well as input from other concerned organizations (see list on back page).

Complete short-range, mid-range and long-range recommendations are included in the **Nursing Agenda for Michigan.** Since the nursing workforce crisis has already begun, we need to take action quickly. Since the crisis will extend over the next thirty years, we need to begin actions now that will benefit all of us in the long term. The Nursing Agenda includes the action steps we must take to ensure an adequate supply of well-prepared, professional nurses — the nurses who will care for us today and in the future.

See the complete Nursing Agenda online at *www.michigan.gov/mdch/ocne.*

What Can We Do Right Away?

The Nursing Agenda recommends the following high-priority **Short-Range Actions:**

Work Changes

1. Promote safe working hours to improve both patient & nurse safety and nurse retention.
2. Improve the organization & design of nursing tasks to make them more efficient and effective.
3. Improve the ergonomics of nursing tasks to improve the health & safety of patients & nurses.
4. Increase shared decision-making to increase nursing input to patient care and safety.
5. Create a more respectful and supportive nursing workplace to improve retention of the existing nursing workforce.

Nursing Education Changes

6. Add nursing faculty by a) increasing slots in fast-track master's programs, b) recruiting faculty from clinical nursing and from both clinical and faculty retirees.
7. Tap into underutilized faculty capacity to increase the number of nursing student slots available.
8. Add new nurses to the workforce by increasing the number of student slots available in second-degree accelerated nursing programs.
9. Maximize the use and availability of web-based instruction and other technologies in nursing education.

Healthcare System Changes

10. Improve nurse retention through improved work design and work environment changes.
11. Improve nursing retention through improved workplace and nursing career supports.
12. Set up collaborative multidisciplinary teams to manage & deliver patient care and increase shared decision-making.

Regulatory & Licensure Changes

13. Increase the outreach and responsiveness of the regulatory apparatus, so that licensure is not delayed.
14. Increase mentoring, support, and oversight for all stages of nursing careers, from student to retirement, by engaging and supporting qualified retired nurses in a multitude of roles.
15. Use an increased nursing licensure fee to provide

The Nursing Agenda for Michigan was created and endorsed by:

The Coalition of Michigan Organizations of Nursing - COMON

American Arab Nurses Association
American Association of Critical Care Nurses, Southeast Michigan Chapter
American Association of Occupational Health Nurses
Association of Women's Health, Obstetric, and Neonatal Nurses
Association of Rehabilitation Nurses, Michigan Chapter
Lambda Chi Chapter, Chi Eta Phi Sorority, Inc.
Detroit Black Nurses Association, Inc.
Maternal Newborn Nurse Professionals of Southeastern Michigan
Michigan Association for Local Public Health,
Health Department Nurse Administrators Forum
Michigan Association of Colleges of Nursing
Michigan Association of Nurse Anesthetists
Michigan Association of Occupational Health Nurses
Michigan Association of Occupational Health Professionals in Healthcare
Michigan Association of PeriAnesthesia Nurses
Michigan Association of School Nurses
Michigan Black Nurses Association, Inc.
Michigan Center for Nursing
Michigan Council of Nursing Education Administrators
Michigan Council of Nurse Practitioners
Michigan League for Nursing
Michigan Licensed Practical Nurses Association
Michigan Public Health Association, Public Health Nursing Section
Michigan Nurses Association
Michigan Organization of Nurse Executives
Michigan State Board of Nursing
National Association of Hispanic Nurses, Michigan Chapter
National Association of Pediatric Nurse Practitioners, Michigan Chapter
Philippine Nurses Association of Michigan

Other Organizations Endorsing the Nursing Agenda for Michigan

Michigan Department of Community Health
Office of the Michigan Chief Nurse Executive
Michigan Department of Labor & Economic Growth
Michigan Health Council
Michigan Home Health Association

Advisors and Organizations Providing Review for the Nursing Agenda

Michigan Health and Hospital Association: Health Care Careers Task Force
James Epolito, President and CEO, Michigan Economic Development Corporation
Pamela Paul Shaheen, DrPH, Michigan Public Health Institute
Gail Warden, President and CEO Emeritus, Henry Ford Health System
Laurence Rosen, PhD, Public Policy Associates, Inc.

WHAT IS THE MICHIGAN NURSING CORPS?

In her 2007 State of the State address Governor Granholm announced the creation of **the Michigan Nursing Corps.**

Excerpt from Governor Granholm's State of the State on the Nursing shortage, February 7, 2007

One area that demands our special attention is nursing. Today we have a nursing shortage in communities across our state. Yet we have waiting lists of people who are anxious to become nurses. Something's wrong with this picture, and we are going to fix it. Tonight we are launching the Michigan Nursing Corps, an initiative to train new nurses. We will prepare 500 nursing educators to train 3,000 new nurses in just three years. "

Link to entire text:
http://www.michigan.gov/gov/0,1607,7-168--161761--,00.html

The Problem

Michigan's nursing education programs are bottlenecked in their ability to admit, educate and graduate all qualified applicants.

FACT Michigan will be 7000 RN's short by 2010 and 18,000 RN's short by 2015

FACT In 2005, Michigan nursing education programs turned away over 2000 qualified Applicants

The Solution

The Michigan Nursing Corps will provide new classroom faculty and clinical faculty who will, in turn, be able to produce over 3000 additional RN's to serve Michigan citizens.

The initiative will take place over a three-year period.

The Cost

The program will cost $45 million over three years. Nurses receive financial support for their education and, in return, they sign contracts to teach in Michigan nursing education programs.

The Outcome

Michigan will have sufficient nursing faculty to prepare the number of nurses needed to care for Michigan citizens as they age and require significantly more health care. They will also be able to replace the large numbers of nursing faculty who are and will be retiring.

FACT More than 50% of faculty at most Michigan nursing schools are eligible to retire today.

The Return on Investment

For every $1 of the $45 million invested, Michigan's communities will receive $162 of economic value.

FACT Each RN in Michigan brings $75,000 of economic value annually to the community (salary and benefits).

FACT Each year RN's contribute $10.5 billion to Michigan and local economies.

The Funding

There are no current state funds for the Michigan Nursing Corps (MNC). The MNC funding will only be possible if there are new state revenues. The Governor's service tax (2 cents) proposal, if passed, could provide funding for the Michigan Nursing Corps.

For more information contact:

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